

Exhibit A:

Child & Adolescent Service
Intensity Instrument

For Children and Adolescents
Ages 6-18



CHILD & ADOLESCENT SERVICE INTENSITY INSTRUMENT[®]
FOR CHILDREN AND ADOLESCENTS AGES 6-18

USER'S MANUAL

VERSION 4.1



AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

W W W . A A C A P . O R G



CASII User's Manual

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Child and Adolescent Service Intensity Instrument

American Academy of Child and Adolescent Psychiatry

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INTRODUCTION

This manual was designed as a guide to the understanding and use of the Child and Adolescent Service Intensity Instrument (CASII), a comprehensive tool for evaluating service need for youth with mental health challenges. The first section describes the following key elements: the CASII's historical context; the principles guiding level of service intensity determinations; the biopsychosocial dimensions used in the CASII evaluation; and a description of the various levels of service intensity responses. The second section provides a detailed description of the dimensions and the levels of care. Section three provides material used in training, including: case studies, post test questions, and sample questions for collecting information to help complete the CASII. Appendices provide information regarding the System of Care concept and philosophy, a list of resources and a review of the CASII psychometrics.

The CASII was created in response to clinicians, program managers, utilizations reviewers and administrators who called for the development of a common framework for making decisions on the level of service intensity needed in the behavioral health treatment of children and adolescents, and to monitor progress over time. The current evolving framework of health care reform places emphasis on the use of validated and reliable metrics to guide treatment needs and monitor outcomes (Wotring & Stroul, 2011). The CASII is such a metric.

The CASII is based on the Level of Care Utilization System (LOCUS) developed for use with adults, but has been adapted to reflect a developmental perspective, family focus, and inclusion of the comprehensive array of services in systems that serve children and adolescents. The instrument was developed collaboratively by the American Academy of Child and Adolescent Psychiatry (AACAP) with the American Association of Community Psychiatrists in 2001 and first named the CA-LOCUS. Subsequent refinement of the tool has moved from a primary concern with "level of care" to a broader perspective involving intensity of overall need, with a focus on services and integrated service coordination, resulting in the renaming of the instrument to CASII.

In most cases, the CASII may be applied to children ages 6 through 18 years. Because the service needs of infants and toddlers are fundamentally different than those of older children, they are excluded from the CASII evaluations. The service intensity needs of children under the age of 6 years should be determined by use of the Early Childhood Service Intensity Instrument (ECSII), developed by the AACAP in 2009.

The CASII draws from clinical experience and a number of values, principles, and resources, including:

- CASSP/Guiding Principles for Systems of Care (1983): This approach has been the primary value base of SAMHSA and State Health and Human Services for the past 30 years. The System of Care values and principles call for care that is family-driven and youth-guided, culturally competent, strength-based, coordinated, community-based and least restrictive, emphasizing early intervention and prevention, transition to adulthood, and outcomes-based. (Stroul, Blau, and Friedman, *System of Care Values and Principles Updated*; Stroul and Blau, *Handbook of System of Care*; Winters, Pumariega, et al,

2007). In recent years, the System of Care approach has also incorporated wellness, prevention, and early intervention as part of its overall commitment.

- Developmental theory (Harris, 1995; Gilmore and Meersand, 2014), which describes the trajectory of normative physical, emotional, cognitive, and social changes of childhood and adolescents, to be addressed in both assessment and treatment.
- Cultural competence (Cross et al., 1998; Pumariega, et al, 2013), which embodies respect for people of all ethnic backgrounds, accommodation of their needs and priorities (e.g. culturally appropriate assessment and treatment, linguistic support) and whenever possible, provision of services by culturally competent professionals and staff members whose ethnic diversity mirrors that of the populations served. Cultural factors often impact the assessment of comorbidity, level of functioning, environmental support, and treatment and engagement, thus potentially biasing diagnosis, treatment planning, and level of care placements.
- Clinical Knowledge: The CASII provides an objective appraisal of the service needs of children and adolescents with mental health disorders, incorporating consideration of co-occurring substance use, developmental disorders, physical health diagnoses, family and community contexts, and the child/adolescent's and the family's response to treatment efforts.
- Wraparound concepts, which entail the integration of a comprehensive network of professional and natural community-based supports for the child or adolescent and family; as well as multi-system structures capable of providing blended and flexible funding to provide services and supports (VanDenBerg and Grealish, 1996). This model supports the use of a strength-based, Individualized Service Plan (ISP) for each child and adolescent. Furthermore, Wraparound concepts have been recognized by the federal Centers for Medicare and Medicaid Services (CMS) as a reimbursable service through Medicaid, as part of Intensive Care Coordination. Wraparound now has an established evidence-base and accepted role within child and adolescent psychiatric care (McGinty, et al, 2013).
- Clinical expertise of psychiatrists serving children and adolescents, and young adults with a variety of psychiatric, substance use, and developmental disorders.

Psychometrics and Evidence

The initial field testing of the CASII was performed in a variety of settings to establish both reliability and validity, even with relatively brief training (6 hours) (Fallon, et al, 2006). Subsequent studies in Tennessee, Hawaii and Minnesota have extended the evidence base supporting the validity, reliability, and utility of the CASII child welfare, juvenile justice, and other mental health settings. These studies are reviewed in detail in Appendix C

Conclusions

The CASII has been designed with awareness of the roles and mandates of the various child-serving systems - including mental health care, physical healthcare, education, child welfare, developmental disabilities and juvenile justice - and the needs of children within these systems. On an individual level, the purpose of the CASII is to assist in determining the needed level of service intensity for an individual child and family, in order to address existing biopsychosocial disorders or disruptions. On a more global level, the CASII can assist the human services field in balancing the equation between individual clinical need on the one side and resource availability on the other side.

Systems of Care (SOC) has been identified as the preferred approach to support implementation of the Health Home within healthcare reform for children and adolescents with serious mental health challenges (Pires, 2013). Health care reform requires use of standardized, validated measures to inform initial Individualized Service Plans, and to monitor ongoing progress. The CASII is a time-tested resource based on a SOC approach that addresses this need. The CASII's design supports population-based care with a wellness orientation that pays explicit attention to the strengths and resiliencies in the child, family, and surrounding community. The CASII can be helpful in improving mental health services in primary care (AACAP and AAP, 2009). In a comprehensive review of level of service intensity determination tools, Lyons (16) evaluated the CASII favorably, citing its clinical utility

Since its introduction in 2001, training in the CASII has been provided to 30 sites in 25 states as well as in Canada, Japan, and Belgium (translated to Japanese and Dutch). Most of these sites have been with public sector agencies, but training has also been requested recently by specific private insurance companies. The Minnesota Department of Human Services (DHS) has had experience with the CASII over the past several years. Leadership from Minnesota DHS wrote the following summary, highlighting some of the strengths of the CASII:

We needed a standardized way of monitoring the clinical/functional status of all children receiving publicly funded mental health service system. The committee charged with finding an appropriate measure recommended the CASII and the SDQ be used together. We conducted a two-year pilot study that resulted in a recommendation that these tools be used by all children's mental health providers serving children in our Minnesota Health Care Programs. The obvious benefit for us has been that we have a standardized mechanism for assessing the service intensity needs of children across the state. We have language that is familiar to everyone involved in treating these children. We also have a standardized way to look at clinical/functional change over time.

SECTION I

HISTORICAL PERSPECTIVE

The need for the CASII stems from the progressive development, since the mid-1980s, of Systems of Care for children and adolescents with serious behavioral health challenges. These systems have been further impacted by the development of managed care during the 1990s and health care reform and the Affordable Care Act in the 2010s. These three threads in the development of children's mental health services have resulted in the majority of children and adolescents being treated primarily in community settings with less reliance on inpatient and residential treatment services and with more integration of behavioral health care with primary care. The CASII provides a framework for defining the appropriate nature and intensity of professional services and natural, community-based supports, in order to meet the needs of children and adolescents with serious behavioral health challenges and their families.

Jane Knitzer's 1982 book, Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents In Need of Mental Health Services, was the first to identify significant services gaps for those children most in need of care. She also found that many children were inappropriately receiving services at a more restrictive level of care due to a lack of alternative resources. Ms. Knitzer was perhaps the first to recommend "a coordinated range of services for troubled children and adolescents" and the development of "placement standards...that ensure children are placed in hospitals only when necessary."

The Federal Child and Adolescent Services System Program (CASSP) was founded in 1984 as a response to these identified problems. The 1986 monograph, A System of Care for Children and Youth With Serious Emotional Disturbances, by Beth Stroul, M.Ed. and Robert M. Friedman, Ph.D., clearly articulates the need for a coordinated continuum of care that includes a broad array of community-based services. The monograph also provided a set of "Guiding Principles" for the development of local systems of care. The values and principles of SOC have been further elaborated and expanded in the *Handbook on SOC* (Stroul and Blau) and *SOC Values and Principles Updated* (Stroul and Blau) to emphasize the importance of prevention, early intervention, transition to adulthood, and measurement of outcomes to determine effectiveness of the service plan. These principles are included in Appendix A.

Also essential in the development of multiple levels of service intensity are the principles of "Wraparound" or "Individualized Service Planning." The development of a Wraparound, or Individualized Service Plan for a child does not rely solely on pre-existing programs or agency services. Rather, it is a comprehensive, coordinated, individualized, and culturally sensitive plan, using both formal and informal supports, to address needs and build on existing strengths of the child and his/her family and community. Augmented by the inclusion of a range of community-based, in-home services, the System of Care approach has been implemented in many areas so that children and adolescents can now be safely and effectively treated in community settings who previously received care in out of home placements.

The Affordable Care Act has placed a greater emphasis on using cost-effective services that are guided by measurement of outcomes. Too often, there has been disagreement between payers,

providers and consumers as to the most appropriate level of service intensity. VanDenBerg and Grealish pointed out in a 1996 article that, "If the adults disagree, the child fails." The CASII helps to provide a consensus on level of service intensity needed and a metric to monitor progress of the child or adolescent in response to the services provided. The CASII takes account of the impact of comorbid developmental, substance abuse and medical conditions in determining the overall service intensity need. The emphasis on coordination and integration of care for comorbid conditions within the current health care environment further underscores the relevance of the CASII in order to help guide care planning. Moreover, the CASII provides a reliable and valid method to assess service intensity to support effective care planning that takes into account child and family strengths and the promotion of wellness and recovery.

FOUNDATIONS AND PRINCIPLES

The CASII begins by defining a set of dimensions that are relevant to the child's clinical status and environment: Risk of Harm, Functional Status, Co-Occurrence of Conditions, Recovery Environment, Resiliency and Response to Services, and Involvement in Services. The CASII dimensions are described in detail in Section II. The dimensions are rated through use of defined scales that are quantified, in order to convey information easily. Each scale constitutes a spectrum, along which a child or adolescent may lie for any given dimension. Thus, these individual dimension scores are combined to provide a composite rating score. In this way, the CASII integrates multiple dimensions, guiding the user to an appropriate level of service intensity. The CASII also provides valuable dimension-specific information about the child and family, which can be addressed through treatment and monitored over time. As a result, the CASII assists with treatment planning for a child and family at both a highly integrative, global level and at the level of specific dimensional need.

Cultural competency is essential for accurate use of the CASII. A clear understanding of the cultural factors influencing each dimension is important; the dimensions of Environmental Support and Involvement in Services are particularly sensitive to these factors. The use of a cultural consultant or community resource person identified by the family may be very helpful in situations where there is a lack of clarity. In all the dimensions, it is essential that the clinician consider the culture of the child or adolescent and the family, and adapt the rating to this cultural set.

In order to develop an instrument applicable to a wide variety of service environments and child or adolescent needs, it was important to develop a set of definitions for levels of service intensity that describe the resources needed at each specific level. These definitions need to be flexible and adaptable, in order to be broadly applicable to the wide variety of service environments in which care is given. This approach was chosen to allow service providers to give adequate clinical services and quality care in the most economic and realistic fashion.

The CASII employs multi-disciplinary/multi-informant perspectives on children and adolescents and is designed to be used by a variety of mental health professionals, ideally within a child and family team context. Although the CASII may be used for initial service intensity decisions, it may be used at all stages of intervention to monitor response to treatment and to reassess the level of intensity of services needed. An important aspect of the CASII is its potential use for utilization management within a population-based, wellness-oriented system of care. Many instruments in the past have developed separate criteria for hospital admissions, continuing care and discharge planning. The CASII instrument makes it unnecessary to use different criteria because of the dynamic nature of interaction of the quantifiable dimensional ratings

There are a number of functions that the CASII is not designed to serve. It does not prescribe program design, but rather the type and intensity of resources that are needed for particular levels of service intensity. It does not specify the type of intervention, and it does not eliminate the importance of clinical judgment. The CASII, with its focus on service intensity rather than level

of care, creates opportunities for the development of specific service responses that meet the needs of special populations or localities. The identification of specific service responses is the task of the clinician, in partnership with the child and family and others who comprise the treatment team.

SECTION II

CASII DIMENSIONAL RATING SYSTEM

The CASII dimensional rating operationalizes six factors that clinicians need to consider in determining the most appropriate level of service intensity and services needed. Each dimension has a five point rating scale, from least to most severe. For each of the five possible ratings within each dimension, a set of anchor points are provided. **Only one anchor point needs to be met for that rating to be selected.** Therefore, for each dimension, the highest rating in at least one of the anchor points met is the rating that should be assigned. These anchor points assist the clinician in determining a rating for that dimension. However, it is the responsibility of the clinician to consider the cultural set for the patient and family and decide on a rating that is appropriate to the clinical situation.

Identification of the Dimensions

The CASII's six dimensions are identified and described below:

- **RISK OF HARM:** This dimension helps to identify the risk to the child and adolescent from a number of potential causes of harm, both within the individual and from their environment. Internal risks may include a child's level of impulsivity that may put their safety at risk or an adolescent's substance abuse which may lead to many potential risks. External risks include the child or adolescent's risk of harm by others using various means and an assessment of his/her potential for being a victim of neglect, neighborhood violence or physical or sexual abuse.
- **FUNCTIONAL STATUS:** This dimension measures the impact of a child or adolescent's primary condition on his/her daily life. It is an assessment of the child's ability to function in all age-appropriate roles: family member, friend and student. It is also a measure of the effect of the presenting problem on such basic daily activities as eating, sleeping and personal hygiene.
- **CO-OCCURRENCE OF CONDITIONS:** This dimension measures impact of co-existing conditions on the primary focus of treatment. For example, if the primary condition is mental health, then this dimension would rate the impact of the child or adolescent's co-occurring Developmental, Medical and, Substance Abuse conditions on treatment of the primary condition. Remember, if the primary condition is a substance abuse problem, medical illness or a developmental disability, then any psychiatric condition also present would be considered as a co-occurring condition.
- **RECOVERY ENVIRONMENT:** This dimension is divided into 2 subscales: Environmental Stress and Environmental Support. An understanding of the strengths and needs of the child or adolescent's family is essential to choosing an accurate rating in this dimension. An accurate rating depends on the ability of the rater to "walk a mile in the child and family's shoes." It is also a measure of the neighborhood and community's role in either complicating or improving the child or adolescent's condition. Thus, high ratings on both

these subscales (Extreme Stressful Environment and No Supportive Environment) will have a major impact on both the composite score and the actual level of service intensity chosen.

- **RESILIENCY AND/OR RESPONSE TO SERVICES:** Resiliency refers to a child or adolescent's innate or constitutional emotional strength, as well as the capacity for successful adaptation (Rutter, 1990). The concept of resiliency is familiar to clinicians who work with children or adolescents and families who have the most severe disorders and/or survive the most traumatic life circumstances, yet who either maintain high functioning and developmental progress, or use services for a rapid return to that state. This dimension also measures the extent to which past services have been effective for the child or adolescent and his/her family. Ratings in this dimension are particularly sensitive to those deficits seen in autistic spectrum disorders.
- **INVOLVEMENT IN SERVICES (Scale A--Child/Adolescent, Scale B--Parents/Primary Caretaker):** This dimension is divided into two subscales to allow for measurement of both the child or adolescent's and his/her family's involvement in services. This dimension is intended to capture those elements of engagement that are internal to the child/adolescent or the parent/primary caretaker and those elements that are due to factors within an individual service provider or treatment team that limit their ability to participate in treatment. Remember: Only the highest subscale score (the subscale indicating the most significant challenge to involvement in services is used in calculating the composite score.

Use of the Dimensions

In order to understand what each rating within a specific dimension is measuring, it is important to review the introductory discussion for each dimension carefully, beginning on page 19.

Remember, you want to select the highest rating in each dimension, where at least one of the criteria is met. In some cases, the actual clinical picture may not fit any of the criteria on the rating scales exactly. In that situation, you should select the closest fit and the rating that most closely approximates the actual condition of the child or adolescent.

When there is some confusion about which rating should be assigned and you are not certain which is the closest fit, choose the higher rating. No instrument can anticipate every circumstance or be applicable to every situation, so clinical judgment will be needed. Within the framework of the identified guidelines, the clinician makes a determination as to which rating within each dimension is most appropriate. The clinician should base these determinations on interviews with the child or adolescent, the family, and all other available clinical information. Sources of information may include, but not be limited to, written clinical reports and summaries of mental health status examinations, school records, external agency reports, family interviews, and information provided by others identified by the family.

In the evaluation of children and adolescents, a multi-informant approach that integrates information about the child and family from multiple sources and observers should be used. Scores in the CASII are based on the child or adolescent's status at the time of administration of the instrument. Scores for a particular child or adolescent can be expected to change, especially in crisis situations and as interventions are implemented. When a child's life circumstances are

stable or functioning has not deviated much from baseline, scores may not change dramatically. Clinicians should use their judgment or be guided by agency protocols, in determining how frequently to re-score the instrument over the course of service delivery. As a general rule, the CASII should be scored at the beginning of services, at points of significant change (such as on consideration of a change in service intensity), and at the termination of services. Under most circumstances, the CASII should be scored more frequently at the higher levels of service intensity.

LEVELS OF SERVICE INTENSITY

The levels of service intensity in the CASII are organized in a unique way. The focus is on the level of resource intensity, which is flexibly defined in order to meet the child or adolescent's needs. Each level of service intensity is defined by a combination of service variables: clinical services, support services, crisis stabilization and prevention services, care environment. Some levels of service intensity may contain the same resources found at other levels of service intensity. With higher levels of service intensity, a greater number and variety of services are utilized. In addition, the need for active case management of services - in particular, intensive care coordination - increases at the higher levels.

The levels of service intensity are defined so that they can be effectively used regardless of the extent of collaboration in a local system of care. In a community with a more traditional array of services, the higher levels of service intensity will necessarily be provided in residential or inpatient settings. In areas where there is an active use of the Wraparound process in a community-based system of care, the higher levels of intensity of service can be provided in the least restrictive environment possible.

One way to think about the levels of service intensity is to compare them with the difference between the services available in a single pediatrician's office (the lower levels of service intensity) and a major medical center (higher levels of service intensity). For well-baby checks and most common medical conditions, a child or adolescent can be treated in the pediatrician's office. For more complex problems, especially those that are potentially disabling or life-threatening, service at a major medical center would be appropriate due to the wider array of services and the availability of specialists.

In the CASII, there are seven levels of service intensity:

Level 0: Basic Services.

This is a universal base of prevention and health maintenance services that should be available to everyone in the population.

Level 1: Recovery Maintenance and Health Management.

This level of service provides initial community-based support for children and adolescents with limited need for formal services. In general, it is expected that Level 1 services can be provided within the youth's community and primary care/medical home setting without involving specialty behavioral health services. Examples would include a child and adolescent with uncomplicated ADHD whose medical management can be achieved via medication administration with ongoing primary care support, or a youth or family in need of brief assessment and counseling for an adjustment disorder

Level 2: Outpatient Services.

This level of intensity most closely resembles traditional outpatient services with licensed mental health professionals involved in ongoing care. However, the CASII does not prescribe where these services may be provided: they may be offered in a number of community settings, including within the patient-centered medical home, school-based mental health, and in-home therapy, in addition to traditional office or clinic-based outpatient care.

Level 3: Intensive Outpatient Services.

Formal care coordination may begin at this level. The use of family-driven, youth-guided teams to develop Individualized Service Plans (ISP) also begins but it is not required. The use of combination of clinical services and natural community resources such as faith-based or other community supports and services, such as Boys and Girls Clubs. Home and community-based mental health supports and services may be provided in conjunction with specific services as identified within the child's Individual Education Program (IEP), giving rise to particular need for care coordination. [Note: It is unlikely, for financial reasons and reasons of liability, that an IEP will "identify" the need for a child to receive mental health services in school, since this "should" be provided by the MH system. The IEP, however, could identify other relevant services for the child]. This level of service intensity requires more frequent contact between providers of care and the youth and his or her family, as the severity of disturbance increases.

Level 4: Intensive Integrated Services Without 24-Hour Psychiatric Monitoring.

At this level, a more elaborate individualizes service plan or Wraparound plan is required, identifying an increased number of services and supports. The wraparound planning process involves a dedicated Care Coordinator, most often in concert with a Family Partner or Peer Support Specialist for the parent and at times a Youth Partner or Peer Support Specialist for the adolescent, to help promote and maintain engagement in the care planning process. Additional supports may include respite and homemaking services for the family, or paid mentors for the child or adolescent. In more traditional systems, Level 4 service is often provided less comprehensively in a day treatment or partial hospitalization setting. The development of a detailed Crisis Plan is essential at this level of service intensity.

Level 5: Non-Secure, 24-Hour Services With Psychiatric Monitoring.

Traditionally, this level of care has been provided in group homes or other unlocked residential facilities. It may, however, be provided in intensive foster care and even family homes if the level of community services and supports achieved through a Wraparound planning process is sufficiently intense and comprehensive. In either case, an intensive array of services should be in place around the child, and a higher level of care coordination and family support is needed in order to address the child, and frequently the family's, multiple needs. Psychiatric services are provided to support clinical assessment, evaluate clinical response and manage psychotropic medication interventions, when

indicated.

Level 6: Secure, 24-Hour Services With Psychiatric Management.

Generally, these services are provided in secure inpatient psychiatric settings or highly programmed residential facilities. Admission to an inpatient unit represents an intensive treatment intervention, and should occur in coordination with the child's community-based team. One expectation for care at Level 6 is that it will have the capacity to provide specialty assessment and consultation to the child and family. In addition, Level 6 care also requires close collaboration between the inpatient facility and the community-based treatment providers to ensure that the appropriate array of community-based supports and services is available to the child or adolescent at the time of discharge. The community-based providers must be an integral part of discharge planning, in order to facilitate the child's successful return to the community.

LEVEL OF SERVICE INTENSITY DETERMINATION

Each of the six dimensions is defined along a scale of one to five, with higher scores reflecting increasing levels of concern. Each score in the scale is supported by identified anchor points. **The clinician should select the highest rating level in each dimension that most accurately identifies the child or adolescent's condition.**

Once scores have been assigned in all six dimensions, the scores can be recorded on the worksheet and summed up, to obtain a composite score. From here, there are three methods to determine a recommended level of service intensity: a simple table; a decision tree algorithm; and a service intensity determination grid. Using the service intensity determination grid provides a rough estimate of the level of service intensity recommendation. Regardless of the method used, it is important that the family accept the recommended service intensity of services to be provided. The family has the option to choose a lower level of service intensity, unless the child or adolescent is being involuntarily committed for his or her own safety or the safety of others.

An important feature of the CASII is that, independent rating criteria are identified within selective dimensions that automatically place the child or adolescent in a higher level of service intensity, irrespective of the scores in other dimensions. For example, a child or adolescent score that is very high in suicidal or dangerous behavior is assigned to a level six intensity of service, which usually involves a locked psychiatric setting, regardless of other scores or circumstances. These independent criteria are marked in the Level of Service Intensity Determination Grid (see page 55). Although the independent criteria may predetermine the level of service intensity, for treatment planning and treatment monitoring purposes, it remains important to complete the entire CASII, so as to obtain ratings in each dimension and a composite score.

One additional aspect of the role of the CASII in treatment planning needs to be recognized. It is not just the overall CASI score but also the scores for specific dimensions that are important to track, but there is useful information to be gained from tracking individual dimension scores as well. For example, Risk of Harm -- a high Risk of Harm score reflects that the child's safety is compromised, requiring ongoing monitoring. Serial administrations of the CASII will help to track changes in critical dimension over time.

When a service system does not have comprehensive services for a child or adolescent at every level of the continuum, then the level of service intensity identified by the CASII may not be available. In making a choice under such circumstances, in most cases the clinician should select the higher level of service intensity, unless there is a clear and compelling rationale to do otherwise. **There is benefit in erring on the side of caution and safety, rather than risk and instability.**

It is thus important for clinicians to be aware of the service array available within their service system for each level of service intensity. While at times a limited service capacity may lead to use of a higher service intensity level, at other times this information becomes the starting point

for more intensive service planning, Individualized service planning requires creativity by a team to identify and then obtain specific services and supports for a particular child or adolescent and family. The fact that a service does not yet exist should not be seen a barrier, but should serve as a stimulus for the team to determine ways to use existing resources and supports to meet the priority needs identified by the CASII. Attention to cultural needs and issues is also part of the planning process.

Clinicians should appreciate that using the CASII does not require memorization of the definition of each level of service intensity or the specific elements of each rating level within a dimension. However, over time the user becomes more familiar with the instrument, and CASII scoring can be achieved more quickly.

By offering a methodology that is not prescriptive, the CASII is flexible and adaptable. It identifies a level of service intensity and an array of services within each level, rather than specifying a specific treatment setting or program. These characteristics allow the CASII to be used in a broad range of service systems in a manner that illuminates, rather than dictates, service choices.

SECTION III

CASII INSTRUMENT

Evaluation Parameters for Assessment of Service Needs

Definitions

DIMENSION I. RISK OF HARM

The Risk of Harm dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming him/herself and of harming others. Risk of Harm most frequently is manifested by suicidal or homicidal behavior. In addition, the following factors may also give rise to Risk of Harm: unintentional harm due to misinterpretations of reality; inability to adequately care for oneself; impulsivity with impaired judgment due to loss of control; and intoxication. Furthermore, Risk of Harm may be manifested by a child or adolescent's inability to perceive threats to safety and take appropriate action to be safe. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. In addition, children of any age who have experienced severe and/or repeated abuse or neglect may be unable to perceive threat or take adequate measures to maintain their safety.

In addition to direct evidence of potentially dangerous behavior or vulnerability from interview and observation, other factors should be considered in determining the likelihood of Risk of Harm. These include the following: history of dangerous behavior; history of abuse and/or neglect; ability to contract for safety; adequacy of available supports; and ability to use available supports. It also is important to be alert to ethnic or racial biases that may lead clinicians to misinterpret behaviors as threatening or dangerous.

1. LOW RISK OF HARM

- a. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation.
- b. No indication or report of physically or sexually aggressive impulses.
- c. Developmentally appropriate ability to maintain physical safety and/or use environment for safety.
- d. Low risk for victimization, abuse, or neglect.
- e. Other:

2. SOME RISK OF HARM

- a. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention and no significant distress.
- b. Mild suicidal ideation with no intent or conscious plan and with no past history.
- c. Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others.
- d. Substance use without significant endangerment of self or others.

- e. Infrequent, brief lapses in the ability to care for self and/or use environment for safety.
- f. Some risk for victimization, abuse, or neglect.
- g. Other:

3. SIGNIFICANT RISK OF HARM

- a. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
- b. No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior.
- c. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g. status offenses, impulsive acts while intoxicated; self-mutilation; running away from home or facility with voluntary return; fire-setting; violence toward animals; affiliation with dangerous peer group.)
- d. Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors.
- e. Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways.
- f. Serious or extreme risk for victimization, abuse or neglect.
- g. Other:

4. SERIOUS RISK OF HARM

- a. Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family's ability to carry out the safety plan is compromised.
- b. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals).
- c. Indication of consistent deficits in ability to care for self and/or use environment for safety.
- d. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
- e. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.
- f. Other:

Note: A rating of serious risk of harm requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

5. EXTREME RISK OF HARM

- a. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior;
 - i. Without expressed ambivalence or significant barriers to doing so, or
 - ii. With a history of serious past attempts that are not of a chronic, impulsive, or consistent nature, or in presence of command hallucinations or delusions that threaten to override usual impulse control.

- b. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan, or intent, and no insight and judgment (forcible and violent, repetitive sexual acts against others).
- c. Relentlessly engaging in acutely self endangering behaviors.
- d. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.
- e. Other:

Note: A rating of extreme risk of harm requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION II. FUNCTIONAL STATUS

Functional Status involves one's ability to engage in developmentally appropriate activities of living and experience developmentally appropriate patterns on a regular, ongoing basis. It identifies areas of strength or impairment in functioning in the child or adolescent's life: as a family member, as a student, as a friend and if the adolescent is employed, as a worker. In addition, this measures the child or adolescent's developmentally appropriate ability to care for themselves as well as identifying changes in sleeping or eating patterns; activity level and sexual interest. Functioning may be compared against what would be expected for a child or adolescent at a given developmental level, or may be compared to a baseline functional level for that individual. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on Dimension I (Risk of Harm), such as the failure of a child with intellectual disability to understand the risk of safety when crossing a busy intersection. Clinicians also need to be aware that psychosocial functioning may be underestimated in the context of low socioeconomic status or different expectations about functioning for children and adolescents of culturally distinct backgrounds.

1. MINIMAL FUNCTIONAL IMPAIRMENT

- a. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/hygiene/control of bodily functions.
- b. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative sleep, eating, energy, and self care.
- c. Other:

2. MILD FUNCTIONAL IMPAIRMENT

- a. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention.
- b. Sporadic episodes during which some aspects of sleep, eating, energy, and self care are

compromised.

- c. Demonstrates significant improvement in function following a period of deterioration.
- d. Other:

3. MODERATE FUNCTIONAL IMPAIRMENT

- a. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.
- b. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.
- c. Significant physical disturbances in sleeping, eating habits, or activity level that do not pose a serious threat to health.
- d. School behavior has deteriorated to the point that in-school suspension has occurred and the child or youth is at risk for placement in an alternative school or expulsion due to their disruptive behavior. (Absenteeism may be frequent. The child or youth is at risk for repeating their grade.)
- e. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- f. Recent gains and/or stabilization in functioning have been achieved while participating in services in a structured, protected, and/or enriched setting.
- g. Other:

4. SERIOUS FUNCTIONAL IMPAIRMENT

- a. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
- b. Significant withdrawal and avoidance of almost all social interaction.
- c. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
- d. Serious physical disturbances such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten health and functioning.
- e. Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.
- f. Other:

Note: A rating of serious functional impairment requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

5. SEVERE FUNCTIONAL IMPAIRMENT

- a. Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.
- b. Complete withdrawal from all social interactions.
- c. Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
- d. Extreme disruption in physical functions causing serious compromise of health and well being.

- e. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.
- f. Other:

Note: A rating of severe functional impairment requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

DIMENSION III. CO-OCCURRENCE OF CONDITIONS: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC

The Co-Occurrence of Conditions dimension measures the impact of other co-existing conditions on the child or adolescent's primary or presenting condition. This dimension looks at four domains: developmental, medical, substance use, and psychiatric. Coexisting conditions across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive, or additional services. Users of the CASII must be alert to the under-recognition of co-occurring conditions in children from lower socioeconomic backgrounds and culturally distinct backgrounds that are underserved.

NOTE: For CASII scoring purposes:

- Developmental conditions or disabilities include: Autism, Intellectual Disability and Learning Disabilities.
- Physical symptoms related to withdrawal from substance abuse should be considered medical conditions.

Scoring this dimension is a three step process:

- 1) Identification of the primary or presenting condition: generally, this is based on the location in the system of care where the child or adolescent first presents. For example, if a child presents for treatment in a community mental health clinic, then the psychiatric diagnosis or diagnoses would be the primary condition. However, if an adolescent presents at a program for the treatment of substance abuse, then substance abuse would be the primary condition. For a child with Autism Spectrum Disorder presenting at an agency specializing in services to this population, then the Developmental Disability would be the primary condition. For a child or adolescent with a chronic medical problem presenting in a pediatrician's office or community health clinic, then the medical condition would be primary.
- 2) Identifying the co-occurring conditions: in this step, the CASII user will ask if co-occurring conditions are present. For example, for the child presenting in a mental health clinic, the CASII user will identify what co-occurring medical, developmental or substance abuse issues are present. For the adolescent presenting at a program for the treatment of substance abuse, then the CASII user would identify the co-existing psychiatric, medical and developmental conditions. For the child with Autism Spectrum Disorder, the co-occurring psychiatric, medical and substance abuse issues would be identified and for the adolescent presenting at his/her pediatrician's office, the co-occurring psychiatric, developmental and substance abuse issues would be identified.

Remember: if the child has two psychiatric diagnoses (such as anxiety and depression), the second mental health diagnosis would NOT be considered as a co-occurring condition, but just a part of the primary or presenting condition. Similarly, if the adolescent with substance abuse issues is abusing both alcohol and methamphetamine, the second drug of abuse would not be considered as a co-occurring condition, but as part of the primary condition. If the child with Autism also has an Intellectual Disability, this is not a co-occurring condition but is including in the presenting problem. Finally, if the adolescent in the pediatrician's office has both asthma and diabetes, then the second medical condition is not a co-occurring condition, but is part of the presenting problem.

3) Rate the impact of the co-occurring conditions on the treatment of the primary or presenting condition: For example, if the primary condition is Psychiatric (Mental Health), then please rate the impact of the co-occurring substance abuse, developmental and medical conditions on the treatment of the psychiatric condition(s). In a similar manner, rate the impact of co-occurring conditions if the primary condition is Substance Abuse, Developmental, or Medical.

1. NO CO-OCCURRENCE

- a. No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting problem.
- b. Past medical, substance use, developmental, or psychiatric conditions are stable and pose no threat to the child or adolescent's current functioning or presenting problem.
- c. Other:

2. MINOR CO-OCCURRENCE

- a. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and/or compensation.
- b. Self-limited medical problems are present that are not immediately threatening or debilitating and that have no impact on the presenting problem and are not affected by it.
- c. Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting problem.
- d. Transient, occasional, stress-related psychiatric symptoms are present that have no discernable impact on the presenting problem.
- e. Other:

3. SIGNIFICANT CO-OCCURRENCE

- a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of services for the presenting problem or co-occurring condition, or adversely affects the presenting problem.
- b. Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
- c. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem.
- d. Substance abuse is present, with significant adverse effect on functioning and the

presenting problem.

- e. Recent substance use that has significant impact on the presenting problem and that has been arrested due to use of a highly structured or protected setting or through other external means.
- f. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.
- g. Other:

4. MAJOR CO-OCCURRENCE

- a. Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
- b. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.
- c. Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting problem.
- d. Developmental delay or condition is present that will adversely affect the course, treatment, or outcome of the presenting condition.
- e. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.
- f. Other:

Note: A rating of major co-occurrence requires care at a level of 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

5. SEVERE CO-OCCURRENCE

- a. Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- b. Medical condition acutely or chronically worsens or is worsened by the presenting problem.
- c. Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder.
- d. Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting condition.
- e. Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in services for the presenting problem, or otherwise prevent recovery from the presenting problem.
- f. Other:

Note: A rating of severe co-occurrence requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION IV. RECOVERY ENVIRONMENT

The Recovery Environment dimension considers environmental factors that have the potential to impact a youth's efforts to achieve or maintain recovery. Scoring this domain requires identifying those factors that promote resiliency and ongoing success in attaining life's goals, along with those factors in the environment that may have contributed to the onset or maintenance of the primary disorder. The most accurate scoring of the subscales in this dimension may be done by having a clear understanding of how the child and family perceives the environment in which they live, apart from any cultural and socio-economic biases that the CASII user may bring to the situation.

The Recovery Environment dimension consists of two sub-scales: one on Environment Stress, and another on Environmental Support, both of which need to be rated. The influence of the environment on children and adolescents cannot be underestimated, even as they mature to become more autonomous. The Recovery Environment therefore greatly impacts the level of resilience of a child or adolescent (discussed in Dimension 5 below). The recovery environment should not be considered narrowly, but should instead include family, natural supports, school, medical services, juvenile justice, child welfare, and other relevant services.

Supportive elements in the environment include, first and foremost, parent-child attachments and the presence of consistent, supportive, and ongoing relationships with family members. It is important to remember that *family* can be defined in many different ways, and can have different cultural meanings. Other important supportive factors include: availability of adequate housing and material resources, and consistent, supportive relationships with relatives, friends, employers, teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths and therefore seek to obtain this information. The breadth of family, cultural, and community strengths is often not evident in the midst of stressful life circumstances or during acute crisis, but may become apparent after the engagement of ongoing services. The recognition and mobilization of community supports/strengths is a vital component of the recovery process.

The rating of the Recovery Environment dimension is inherently dependent on the child or youth's context, and may change rapidly with a change in level or intensity of services. This dimension may be helpful when considering service needs and/or recruitment of supportive services, especially when considering a change in service intensity. Consider a child or youth in a secure environment being provided with constant monitoring (Level 6) who is doing well, whose home environment is unsafe due to a lack of adult supervision at certain times throughout the day. This child may have difficulty maintaining gains if moved to a lower service intensity without appropriate supportive services being present. This example reveals the complex interaction of environment and service delivery/intensity, and the importance of considering how these elements might change with change in context. When the discharge environment would result in a higher score in the Recovery Environment domain, it may be necessary to mobilize additional services to sufficiently support stabilization and recovery and increase the potential for success. Thus, it may be helpful for service planning purposes to rate both the environment the child is leaving (hospital, residential treatment, foster care, etc.) and the environment that will be receiving the child.

Stressful life elements have the potential to negatively impact a youth or family's level of distress or functioning. They include, but are not limited to: interpersonal conflict, maltreatment and other trauma, life transitions, losses, concerns relating to health and safety, parental impairment, and difficulty in maintaining role responsibilities. It is important to appreciate that even eagerly anticipated family events have the potential to be stressful for a child/youth and/or family. Stressful life events do not include events that the youth has created, such as being expelled from school, but rather include those events that come to the child such as a loss of a parent or a family move.

Environmental Stress

1. ABSENT

- a. Absence of significant or enduring difficulties in environment and life circumstances not expected to change significantly.
- b. Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).
- c. Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.
- d. Living environment is conducive to normative growth, development, and recovery.
- e. Role expectations are normative and congruent with child or adolescent's age, capacities and/or developmental level.
- f. Other:

2. MILD

- a. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher.
- b. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, or illness or death of distant extended family member that has moderate effect on child and family.
- c. Transient but significant illness or injury (e.g., pneumonia, broken bone).
- d. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor.
- e. Expectations for performance at home or school that create discomfort.
- f. Potential for exposure to substance use exists.
- g. Other:

3. MODERATE

- a. Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary care taker, serious legal or school difficulties, serious drop in capacity of parent or usual primary care taker due to physical, psychiatric, substance abuse, or other problem with expectation of return to previous functioning).
- b. Interpersonal or material loss that has significant impact on child and family.
- c. Serious illness or injury for prolonged period, unremitting pain, or other disabling condition.

- d. Danger or threat in neighborhood or community, or sustained harassment by peers or others.
- e. Exposure to substance abuse and its effects.
- f. Role expectations that exceed child or adolescent's capacity, given his/her age, status, and developmental level.
- g. Other:

4. SERIOUS

- a. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment.
- b. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence, or immersion in alien and hostile culture.
- c. Inability to meet needs for physical and/or material well-being.
- d. Exposure to endangering, criminal activities in family and/or neighborhood.
- e. Difficulty avoiding substance use and its effects.
- f. Other:

5. SEVERE

- a. Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy.
- b. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
- c. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
- d. Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.
- e. Other:

Environmental Support

1. OPTIMAL

- a. Family and ordinary community resources address child or adolescent's developmental and material needs without outside intervention.
- b. Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker.
- c. Other:

2. ADEQUATE

- a. Continuity of family or primary care takers is only occasionally disrupted, and/or relationships with family or primary care takers are only occasionally inconsistent.
- b. Family/primary care takers are willing and able to participate in services if requested to do so and have capacity to effect needed changes.
- c. Special needs are addressed through successful involvement in systems of care (e.g., low

- level special education, tutoring, speech therapy.)
- d. Community resources are sufficient to address child or adolescent's developmental and material needs.
- e. Other:

3. LIMITED

- a. Family has limited ability to respond appropriately to child or adolescent's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
- b. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
- c. Family or primary care takers demonstrate only partial ability to make necessary changes during the course of treatment.
- d. Other:

4. MINIMAL

- a. Family or primary care taker is seriously limited in ability to provide for the child or adolescent's developmental, material, and emotional needs.
- b. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.
- c. Family and other primary care takers display limited ability to participate in services and/or the service plan (e.g., not involved).
- d. Other:

5. NONE

- a. Family and/or other primary care takers are completely unable to meet the child or adolescent's developmental, material, and/or emotional needs.
- b. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
- c. Lack of liaison and cooperation between child/youth-servicing agencies.
- d. Inability of family or other primary care takers to make changes or participate in services.
- e. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others.
- f. Other:

DIMENSION V. RESILIENCY AND/OR RESPONSE TO SERVICES

The Resilience and/or Response to Services dimension records a child or adolescent's ability to self-correct and continue to function effectively, when there are disruptions in the environment. This includes the ability to use the environment as well as the child/adolescent's own internal resources. This determination can be made by considering how well the child or adolescent has responded to services in the past, with consideration also given to responses to stressors and life changes.

For children/adolescents who have faced major life changes and respond adaptively, their

resiliency score will be low, reflecting a high degree of resiliency. For children/adolescents who are sensitive to minor changes such as schedule disruptions, the score will be higher. Most children/youth in the autistic spectrum struggle with particular sensitivities that leave them much less flexible to manage the minor bumps of life.

Children and adolescents may respond well to some services and poorly to others. The response to services in some cases may not be related to level of intensity, but rather to the characteristics, acceptability, and/or cultural competency of the service provided. Because children and adolescents rarely have long histories of receiving services, their responses to stressors and life changes in the absence of professional intervention can be particularly helpful.

Specific anchor points are present to address how resiliency may manifest in a child or adolescent with a Developmental Disability. Their ability to transition from one environment or activity to another (and the level of support needed for such transitions) can be seen as an additional measure for resiliency in this population.

The scoring of Resilience and/or Response to Services should be based primarily on the use of recent experiences with services, with less reliance on earlier service experiences. For younger children without prior involvement in services, responses to developmental challenges without professional involvement may be taken as indicative of their resiliency.

Recovery for children and adolescents is defined not only as a period of stability and control of problems, but also as a continuation or resumption of progress toward an expected developmental level for a given child or adolescent.

1. FULL RESILIENCY AND/OR RESPONSE TO SERVICES

- a. Child/youth has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
- b. Prior experience indicates that efforts in most types of services have been helpful in controlling the presenting problem in a relatively short period of time.
- c. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent services.
- d. Able to transition successfully and accept changes in routine without support; optimal flexibility.
- e. Other:

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO SERVICES

- a. Child/youth demonstrated average ability to deal with stressors and maintain developmental progress.
- b. Previous experience with services has been effective in controlling symptoms but more lengthy intervention is required.
- c. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support.
- d. Recovery has been managed for short periods of time with limited support or structure.
- e. Able to transition successfully and accept changes in routine with minimal support.

- f. Other:

3. MODERATE OR EQUIVOCAL RESILIENCY AND/OR RESPONSE TO SERVICES

- a. Child/youth has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
- b. Previous experience with services at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
- c. Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings..
- d. Developmental pressures and life changes have created temporary stress.
- e. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.
- f. Other:

4. POOR RESILIENCY AND/OR RESPONSE TO SERVICES

- a. Child/youth has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
- b. Previous services have not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated interventions.
- c. Attempts to maintain whatever gains that can be attained with intensive services have limited success, even for limited time periods or in structured settings.
- d. Developmental pressures and life changes have created episodes of turmoil or sustained distress.
- e. Transitions with changes in routine are difficult even with a high degree of support.
- f. Other:

5. NEGLIGIBLE RESILIENCY AND/OR RESPONSE TO SERVICES

- a. Child/youth has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.
- b. Past response to services have been quite minimal, even when treated at high levels of service intensity for extended periods of time.
- c. Symptoms are persistent and functional ability shows no significant improvement despite receiving services.
- d. Developmental pressures and life changes have created sustained turmoil and/or developmental regression.
- e. Unable to transition or accept changes in routine successfully despite intensive support.
- f. Other:

DIMENSION VI. INVOLVEMENT IN SERVICES

The Involvement in Services dimension is designed to reflect the quantity and quality of the child/youth and primary caregiver's involvement and engagement in services. For the purpose of the CASII, services include an array of therapeutic interventions to address the child/youth and primary caregiver's needs. The Involvement in Services dimension consists of two sub-scales - one reflecting the child/youth's involvement in services, and the other reflecting the parent or

other caregiver's service involvement. The two sub-scales reflect participation in multiple treatment-related activities – intake, service planning, service implementation, and the maintenance phases of services.

There are many factors that can impact child and parent involvement in service planning and delivery, including experiences with services that are not effective, collaborative, or culturally competent or with service providers who are insensitive, biased or poorly trained. The rating of this dimension does not evaluate the *cause* of limited involvement, but instead rates only the quantity and quality of involvement in services. A high rating in this dimension – e.g., low service involvement – should therefore trigger a collaborative and thoughtful consideration of past and current services, in order to try to determine the likely causes of the low service involvement and identify services and supports that are most appropriate to the identified level of need and will promote participation. The Involvement in Services dimension can therefore serve as an early indicator of the need to modify services or strengthen service relationships, so that there is greater likelihood of positive outcomes.

When the barrier to child and family involvement is culturally based, as with unaddressed cultural difference between clinician and family, consultation with or the addition of cultural specialists may be helpful. However, respectful discussion between the clinician and family may also resolve the issue.

In scoring this dimension, only the higher of the two sub-scale scores (child or adolescent vs. parent and/or primary caregiver) is added into the composite score. In addition, if a child or adolescent is legally emancipated and living independently, then the parent and/or primary caregiver sub-scale is not scored.

Child or adolescent involvement in services

The child/youth sub-scale measures the quality of the child or adolescent's therapeutic relationships as well as the quality and quantity of involvement in service planning and delivery. When rating this dimension, one may need to consider engagement in previous service relationships, although the ultimate score should rely primarily on current participation. The rater should also consider what level of engagement is developmentally appropriate for the child or youth. A higher score reflects consistent inability to follow through on essential components of services (i.e. not attending sessions), lack of engagement in therapeutic relationships with current providers, and/or inability to reach consensus regarding service planning.

1. OPTIMAL

- a. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
- b. Able to define problem(s) as developmentally appropriate and accepts others' definition of the problem(s), and consequences.
- c. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
- d. Cooperates and actively participates in services.
- e. Other:

2. ADEQUATE

- a. Able to develop a trusting, positive relationship with clinicians and other care providers.
- b. Unable to define the problem as developmentally appropriate, but accepts others' definition of the problem and its consequences.
- c. Accepts limited age-appropriate responsibility for behavior.
- d. Passively cooperates in services.
- e. Other:

3. LIMITED

- a. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
- b. Acknowledges existence of problem, but has trouble accepting limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
- c. Minimizes or rationalizes problem behaviors and consequences.
- d. Unable to accept others' definition of the problem and its consequences.
- e. Frequently misses or is late for appointments and/or does not follow the service plan.
- f. Other:

4. MINIMAL

- a. A difficult and unproductive relationship with clinician and other care providers.
- b. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.
- c. Frequently disrupts assessment and services.
- d. Other:

5. ABSENT

- a. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.
- b. Unaware of problem or its consequences.
- c. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.
- d. Other:

Parent and/or primary caregiver involvement in services

The parent sub-scale measures the quality of the parent or caregiver's relationships with the family's service providers, as well as the quality and quantity of involvement in service planning and service. When rating this dimension, one may need to consider engagement in previous service relationships, although the ultimate score should stress current participation. A higher score reflects consistent inability to follow through on essential components of services (i.e. not attending sessions or not bringing child to session), lack of engagement in therapeutic relationships with current providers, and/or inability to reach consensus regarding service planning.

The final score for this subscale is a composite score of all the child or adolescent's primary caregivers, with the most weight given to those parent/caregivers who have most direct impact on the child or adolescent. This means that 2 or 3 caregivers may be rated; for example, in divorced families, rating the involvement of both parents separately will be of value. In a

situation where a child is in foster care and the family of origin remains involved with the child, then the involvement of both households should be rated. If a member of the extended family provides a high degree of support to a child, such as a grandparent or favorite aunt or uncle, then they may be rated as well. Data useful in treatment planning may be derived from these individual parent/caregiver ratings as well; for example, if one divorced parent is highly involved and another is not, then greater emphasis on inclusion of the less-involved parent may be an essential part of the treatment plan.

1. OPTIMAL

- a. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers.
- b. Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting problem.
- c. Sensitive and aware of the child or adolescent's problems and how they can contribute to their child's recovery.
- d. Active and enthusiastic participation in services.
- e. Other:

2. ADEQUATE

- a. Develops positive therapeutic relationship with clinicians and other primary care takers.
- b. Explores the problem and accept others' definition of the problem.
- c. Works collaboratively with clinicians and other primary care takers in development of service plan.
- d. Cooperates with service plan, with behavior change and good follow-through on interventions.
- e. Other:

3. LIMITED

- a. Inconsistent and/or avoidant relationship with clinicians and other care providers.
- b. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
- c. Unable to collaborate in development of service plan.
- d. Unable to participate consistently in service plan, with inconsistent follow-through.
- e. Other:

4. MINIMAL

- a. A difficult and unproductive relationship with clinician and other care providers.
- b. Unable to reach shared definition of the development, perpetuation, or consequences of problem.
- c. Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members.
- d. Engages in behaviors that are inconsistent with the service plan.
- e. Other:

5. ABSENT

- a. No awareness of problem.
- b. Not physically available.
- c. Refuses to accept child or adolescent, or other family members' need to change.
- d. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.
- e. Other:

PART VII

CASII LEVELS OF SERVICE INTENSITY CRITERIA

The levels of service intensity described in the CASII represent a graded continuum of services. At each level of service, a broad range of programming options is described, allowing for variations in practice patterns and resources among diverse communities. Services that may be used to create the needed service intensity often includes both traditional services and services and supports available through the local System of Care. Medical care, particularly those services available through an Integrated Care model may also be used to build the needed level of service intensity. Each level of service intensity includes the services at every level below it.

The System of Care (Appendix A) described in this document includes, but is not limited to, service provided by mental health, child welfare, juvenile justice, health, education, substance abuse, vocational, developmental disability and recreational agencies. In many parts of the United States, there are family-run agencies that provide services within the local System of Care. Natural or community supports supporting the development of the needed level of service intensity may be provided by the family's church, synagogue or mosque, local service agencies such as the Kiwanis or Lions Club or cultural organizations such as La Raza, the nation's largest Hispanic civil rights and advocacy organization. Natural or community supports that may be provided by the child or adolescent's extended family or neighborhood may also be integral to the creation of the needed level of service intensity. Children and adolescents with multiple complex problems usually require the services of multiple components within the system of care. In these cases, integration and coordination of care is essential.

This document advocates for the use of child/youth and family teams, also known as wraparound teams, composed of family members, members of the family's extended family and community, and service providers from all the needed components of the system of care. These teams give families a role in directing care by bringing together all those with the potential to assist the child or adolescent. These teams are given various names in different localities, but should include representatives from as many components as necessary from the local system of care. Optimally, the principles of Wraparound form the basis for sharing resources and blending services in an individualized service plan for a child or adolescent and family (VanDenBerg and Grealish, 1996).

The CASII levels of service intensity also provide rough estimates of the staff time involved in providing services at different levels. The actual service time required by each child or adolescent and family is highly variable and should be determined by the unique needs of the child or adolescent and their family. However, in the aggregate, service time estimates may be of value to program planners.

Level of Service Intensity Transitions

The needs of a child or adolescent and family in services are likely to change as services progress. Level of service intensity transitions need not occur sequentially. For example, a child may transition from the Level Six (the highest level of service intensity, usually provided in an inpatient setting) to a Level Four (a community-based Wraparound Plan with a professional Care

Manager) without receiving Level Five services. It may be desirable, however, for a child or adolescent to remain at a higher level of service intensity to preclude relapse and unnecessary disruption of care, and to promote lasting stability.

A child or adolescent may make the transition to another level of service intensity when, after an adequate period of stabilization, and based on the clinical judgment of the providers and family or the Child and Family Team, the child or adolescent meets the criteria for the other level of service intensity. Re-administration of the CASII can help clinicians and families determine a child or adolescent's readiness for another level of service intensity, and can help identify the foci of subsequent services. A flexible Individualized Service (Wraparound) Plan can facilitate seamless transitions, with the same clinicians and staff providing care at multiple service levels whenever possible. It is especially important for the Wraparound Plan to have a detailed arrangement for how crisis situations will be managed.

Multidisciplinary Service Teams

This document supports the view that many types of agencies and professionals, when providing services within their scope of practice, are integral to the successful care of children and adolescents. Programs should be licensed to offer the requisite services for the levels of service intensity provided and should have the staff and program capabilities necessary to provide those services. In addition, while this document does not specify requirements for the levels of clinician training, clinicians should be highly trained, with applicable licensure and/or certification, e.g., child and adolescent psychiatrists primary care providers licensed mental health, professionals, substance abuse clinicians, and/or pastoral counselors as well as care coordinators, family partners and youth peer mentors.) Clinicians should provide care that is within their scope of practice. Non-credentialed staff or paraprofessionals providing therapeutic services as part of the service plan should receive supervision by licensed practitioners with training and expertise to work with children, youth, and their families.

At all levels of service intensity above Level 0, access to child and adolescent psychiatrists and child psychiatric Nurse Practitioners is an essential element of the service system. Though requirements for Nurse Practitioners vary from state to state, optimally a Nurse Practitioner treating children with complex psychiatric and developmental conditions should complete a supervised practicum and have ongoing supervision of their work. In addition, medical care from either a pediatrician or family medicine physician or Nurse Practitioner must be available in the community for all Service Intensity levels.

The Care Environment for all levels of Service Intensity should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., providing an environment that is welcoming to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, and interpreter services for non-English speaking and/or hearing-impaired attendees).

The levels of service are described along a continuum of restrictiveness and intensity. No recommendations in this document supersede Federal, State, or local licensing or operating

requirements for agencies, programs, or facilities.

Even with conscientious assessment and scoring of the CASII, critical differences among children and adolescents and their families may demand an Individualized Service Plan (ISP) encompassing services at more than one level of service intensity. Informed clinical judgment and service planning with the family take precedence. Reasons for deviation from the level of service intensity identified by the instrument should be documented by the clinician in the case record.

LEVEL 0. BASIC SERVICES FOR PREVENTION AND MAINTENANCE

Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings, most notably in primary care Medical Homes and Accountable Care Organizations (AACAP, 2012). Prevention and community support may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings). The CASII does not assign children or adolescent to a Level 0 service intensity; instead, Level 0 services should be available in every community.

1. **CLINICAL SERVICES.** It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments should be readily available for children and adolescents who screen positive for medical, developmental, behavioral or substance abuse problems. Systematic screening for these per Early Periodic Screening Detection and Treatment (EPSDT) guidelines should be conducted on a regular basis so that problems are identified in a timely manner. Consultative services by mental health professionals should be effectively integrated into all prevention and support functions.
2. **SUPPORT SERVICES.** Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community sites, including schools and adult education centers, day care and recreational/social settings, family resource centers, vocational and social services agencies, and medical settings. Community volunteers and agency staff should be trained to provide prevention services. Parent psychoeducation around effective child behavioral management and early awareness and detection of developmental difficulties should be provided at this level
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or child advanced practice nurses should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to

vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.

4. **CARE ENVIRONMENT.** Prevention and community support activities may occur at many sites, beyond just traditional mental health settings, including Medical Home/primary care site, the child or adolescent's home, schools, faith-based, medical, community-based settings such as youth centers or family resource centers, or recreational settings.

Placement Criteria

All children, adolescents, and families should receive Basic Services.

LEVEL ONE. RECOVERY MAINTENANCE AND HEALTH MANAGEMENT

Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those children and adolescents appropriate for Level One services either may be substantially recovered from an emotional disorder or other problem, or their problems are sufficiently manageable within their families such that the problems are no longer threatening to expected growth and development.

1. **CLINICAL SERVICES.** While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of intensity. When needed, clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. In most cases, children and adolescents at a Level One service intensity will only need a single service from the System of Care, such as ongoing case management or follow-up medication services. Medical care from either a pediatrician or family physician should be available in the community. Such services could be supported by consultation from a mental health professional and behavioral health treatment algorithms as part of an integrated behavioral health program in the Medical Home.
2. **SUPPORT SERVICES.** Level One support services consist mainly of natural supports in the community, including extended family, family friends, and neighbors; community support services such as youth centers and family resource centers, faith-based and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of service intensity have the capacity to access these community resources as needed without professional intervention. Family and youth group psychoeducation around illness management and relapse prevention may also be provided in the Medical Home by the mental health professional.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services should be available to children, adolescents, and families at this level of service intensity. Crisis intervention staff should coordinate care with the child or adolescent's primary clinicians. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or nurses should be available in each community on a 24-hour basis.
4. **CARE ENVIRONMENT.** Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), the Medical Home (as part of an integrated behavioral health program), or in other components in the system of care. The environment should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed services at a more intensive level and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.

COMPOSITE SCORE (Level 1)

10 - 13

LEVEL TWO. OUTPATIENT SERVICES

This level of service intensity includes mental health services for children and adolescents living in the community and their families. It is the level of service intensity that most resembles traditional outpatient services. Level Two services frequently are provided in mental health clinics or clinicians' offices but may also be provided in the Medical Home as part of an integrated behavioral health program, in the family's home and in school settings. Services also may be provided within a juvenile justice facility, child welfare agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and care coordination of the higher levels of service intensity because their families are able to use community supports with minimal assistance, but may be monitored by a case manager as part of population health management. The degree of individualization of services at Level Two is not as extensive as at higher levels of intensity, but continuity of at least one care relationship is highly desirable. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.

1. **CLINICAL SERVICES.** Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in service planning and implementation. Service intensity ranges from one hour every other week, to two hours per week, unless the primary service consists of monthly medication management, such as in uncomplicated Attention Deficit Hyperactivity Disorder

(ADHD). Medical services can be delivered by a primary care physician or a psychiatric extender, such as an advanced practice psychiatric nurse within an integrated behavioral health program, as part of established treatment protocols. Psychotherapy services can also be delivered within that setting by a Masters' level psychotherapist, focused on evidence-based psychotherapies. Psychiatric and culturally competent consultation to the service team should be available. Psychiatric evaluation and medication management may be needed at this level of service intensity. Child and adolescent psychiatrists should be available as consultants to the primary service team for medication services and 24-hour back-up for more complex or non-responsive patients. Other interventions (e.g., occupational, recreational, vocational, and/or expressive therapies such as art, music or dance should be made available as indicated.

2. **SUPPORT SERVICES.** Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; community supports such as youth centers and family resource centers, faith-based and recreational programs; 12-step and other self-help groups; school-sponsored programs; and employment. Family and youth group psycho education around illness management and relapse prevention may also be provided in the Medical Home by the mental health professional. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal case management. Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent's individualized service plan.
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services should be accessible to children, adolescents, and families at this level of service intensity. Furthermore, crisis services should be provided in collaboration with the family's other service providers. Crisis services should continue to include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists or child psychiatric advanced practice nurses should be available on a 24-hour basis.
4. **CARE ENVIRONMENT.** Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), the Medical Home as part of an integrated behavioral health program, in other components of the service system, or in other community settings. The environment should be safe and comfortable for children and adolescents regardless of their developmental level, as well as their families.

Placement Criteria

Children and adolescents with a composite score in the range of 14-16 generally may begin services at, or be stepped down to, Level Two services. Placement at Level Two indicates that the child or adolescent does not need services that are more intensive/restrictive than those offered at Level Two, or has successfully completed services at a more intensive level and primarily needs assistance in maintaining gains realized in the past. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

LEVEL THREE. INTENSIVE OUTPATIENT SERVICES

This level of service intensity generally is appropriate for children and adolescents who need more intensive outpatient services and who are living either in their families with support, or in alternative families or group settings in the community. The Level Three service intensity requires the Treatment Team to begin to "think outside the box," to identify additional service or support that will help the child or adolescent and their family stabilize. The family's and community's strengths allow many, but not all, of the child/youth's needs to be met through natural supports. Targeted or limited care coordination may also be needed at this level of service intensity. Services may be needed several times per week, with daily supervision provided by the family or facility staff. Services may be provided in a mental health clinic or clinician's office, but often are provided in other components of the system of care with mental health consultation.

1. **CLINICAL SERVICES.** Level Three services may include more than one type of therapy service or contact with a therapist may occur at more frequent intervals. More frequent contact with the Child Psychiatrist or Nurse Practitioner may also be an option. Service intensity averages service delivery two or more days per week. Other interventions (e.g., Speech, Occupational, Physical or expressive therapies) must be available as indicated. Access to recreational or vocational services may be that additional service which stabilizes an adolescent's life circumstances. In addition, referrals for clinical services for other family members may be needed. Transition planning for discharge to a lower level of service intensity should be part of the service plan.
2. **SUPPORT SERVICES.** Level Three support services may include care coordination by a culturally competent primary clinician or care coordinator, Family partners and youth peer mentors may be essential to support parent and youth voice in the care planning process and in supporting skill acquisition by the parents and/or youth. Support services for these children, adolescents, and families should emphasize natural supports within the community, such as extended family, neighborhood, faith-based groups, self-help groups and community employers. In addition, families may need support for financial, housing, child-care, vocational, or educational services; these should be included as part of the child or adolescent's individualized service plan.
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services, including child and adolescent psychiatric and nursing consultation should be available at this level of service intensity. Crisis services should be accessible and, when provided, crisis team personnel should contact the family's primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach. An individualized crisis plan may be considered.
4. **CARE ENVIRONMENT.** Intensive outpatient services may be provided in a traditional

mental health setting, in other components of the service system, or in other community settings, such as the family's home. The environment should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria

Children and adolescents with scores in the range of 17-19 generally may begin services at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed services at a higher level and needs assistance in maintaining gains. Consideration for this level of service intensity should include the age, size, and degree of cooperation of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff.

COMPOSITE SCORE (Level 3)

17 - 19

LEVEL FOUR. INTENSIVE INTEGRATED SERVICES WITHOUT 24-HOUR PSYCHIATRIC MONITORING

This level of service intensity refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health professional, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents need intensive, clinically informed care coordination to manage the necessary multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a Child and Family team that includes a dedicated care coordinator and, when desired by the parents or youth, a family partner and/or a youth peer mentor. Services are delivered more frequently and for more extended periods than at lower levels of service intensity. Services at this level include partial hospitalization, intensive day treatment, and home-based care. Level Four services also may be provided in an array of settings including educational, substance abuse, juvenile justice, child welfare, group care, or mental health settings, and/or in the child or adolescent's home. A detailed Crisis Plan and Transition planning for discharge to a lower level of service intensity should be part of the service arrangements.

- 1. CLINICAL SERVICES.** Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and nurse practitioners should be determined in consultation with the primary clinician and the Child and Family Team. Primary medical care must be accessible as an integrated part of the comprehensive array of services. Interventions may include individual, group, and family therapy, and may be organized into protocols such

as occur in day treatment, and offered as part of a comprehensive Wraparound Plan, or Individualized Service Plan (ISP), and with emphasis on building on the strengths of the child or adolescent and family.

2. **SUPPORT SERVICES.** Level Four requires that professional care coordination services are provided to manage the multi-faceted service needs of the children and adolescents and their families. Recreational activities, after-school employment, faith-based programs, and other community resources such as youth centers and family resource centers should be integrated into the Individualized Service Plan (ISP) to form a more elaborate network of natural, clinical, and culturally congruent supports. Assistance for the child or adolescent's family becomes essential to building the needed service intensity at this Level; families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Services must be family-centered, with the goals of either maintaining or reintegrating the child or adolescent into the home and community and with attention to addressing needs that are prioritized by the family, as long as they relate to improving the child or youth's functional status.
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** At Level Four, consultation or direct contact with the Child Psychiatrist or Nurse Practitioner may be needed more frequently to maintain a child or adolescent in a community setting. Mobile crisis services are essential to community stabilization at this level of service intensity. n. A detailed crisis plan, developed in collaboration with the Child and Family Team is mandatory. Access to specialty providers (such as those with experience in the management of substance abuse disorders or developmental disabilities) during a crisis may also be important. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of service intensity.

At Level Four, respite care, including planned respite, may be a necessary resource to families to provide relief from the demands of caring for the child or adolescent and as a "cooling off" mechanism during crises and while service plans are implemented.
4. **CARE ENVIRONMENT.** Level Four services may be provided in wherever they are needed in order to maintain a child or adolescent in their family home or other community placement. The family's transportation needs must be addressed in order to support their access to needed facility-based services. Interpretation services are essential to ensure the needed level of involvement in services by the family.

Placement Criteria

Children and adolescents with scores in the range of 20-22 generally may begin services at, or be stepped down to, Level Four services. Consideration for this level of service intensity should include ability to maintain the safety of the child and community within a community-based, outpatient setting.

COMPOSITE SCORE (Level 4)

20 - 22

LEVEL FIVE. NON-SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MONITORING

The essential element in this level of service intensity is the maintenance of an environment in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of service intensity traditionally has been provided in non-hospital settings such as residential care or therapeutic foster homes. Equivalent services have been provided in juvenile justice settings and could be provided in homeless and/or domestic violence shelters or other community settings.

The continued use of Wraparound services is essential at a Level Five service intensity. Use of Wraparound may make it possible to provide Level Five services in a child or adolescent's home, if adequate resources can be provided in order to ensure a safe and intensive treatment environment in the less restrictive setting. If so, the Crisis Plan must be quite detailed and access to needed "back-up" services must be immediate. The Wraparound/Child and Family Team Process must also be used when a child/adolescent is nearing discharge from a more traditional site for Level Five services; a complex array of services and a very detailed crisis plan will be needed to ensure a successful re-integration into their family and community.

Ideally, the step-down plan represents a modification of the comprehensive Level Five service plan, providing continuity of care and sustaining the gains made. This is facilitated by the same service team following the child/youth across different levels of service intensity. This means that the child/youth's community-based wraparound team should remain involved if the child or youth requires out of home placement. If no community-based wraparound team exists, a primary goal of the out of home placement should be to support the family to create such a team that can then assume Individualized Service Planning and care coordination support after transition to a lower level of service intensity (Building Bridges document reference).

- 1. CLINICAL SERVICES.** The same intensity of clinical programming must be provided whether children or adolescents are in residential settings, or in a community setting with an intense Wraparound Plan. The primary clinician should review the child or adolescent's progress daily and coordinate with other members of the treatment team as needed. Child Psychiatrists or Nurse Practitioners are integral members of the service team and may serve in care management roles when coordination with other physicians and/or institutions is needed. More frequent contact for adjustment of the child or adolescent's medication regimen may be needed. Family and individual therapy services are almost always needed at this level of services intensity. Access to counselors with specialized knowledge, such as those with expertise in substance abuse or autism spectrum disorders may be essential. Many of the children and adolescents at this level of service intensity will have co-occurring medical conditions, requiring that the primary care physician be an integral member of the treatment team. The Treatment Team also often includes Family Support Partners (the job title for parents with "lived experience" raising a child with mental health challenges who now work within the System of Care varies from state to state) as well as Peer Mentors for adolescents when needed.

The goal of services for children or adolescents in out-of-home or residential placements

is a timely return to their family and community. Therefore, clinician participation in transition planning is essential.

2. **SUPPORT SERVICES.** Care coordination is integral to care at Level Five regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes with residential staff may be needed to help the adolescent learn how to safely re-integrate into community living. Those children or adolescents receiving services as part of an intensive Wraparound Plan may require a trained escort when attending needed appointments or recreational activities in the community. Families may need even more intensive support for problems with housing, childcare, finances, legal, and job or school problems. These services should be integrated into the child or adolescent's individualized service plan.
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** Although this is not necessarily the case, children and adolescents at Level Five may require higher levels of care for brief periods to manage crises and maintain safety. Services may include face-to-face contact with a child psychiatrist or nurse practitioner, either in the crisis facility or as part of an intensive community intervention.

More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent's risk of harm status or sudden deteriorations in functioning. Re-evaluation using the CASII may yield a composite score supporting admission level six.

4. **CARE ENVIRONMENT.** When care at level five is provided institutionally, living space must be provided that offers reasonable protection and safety given the developmental status of the child or adolescent. Staffing and interpersonal engagement are the primary methods of providing security. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room and maintain supervision of the other children or adolescents).

Placement Criteria

Children and adolescents with scores in the range of 23-27 generally may begin services at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed services at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and degree of cooperation of the child or adolescent, and the family and community resources available.

COMPOSITE SCORE (Level 5)

23 - 27

LEVEL SIX. SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MANAGEMENT

Level Six services are the most intensive and often, but not necessarily, the most restrictive in the level of service intensity continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of service intensity also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these settings are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent's home, if the multiple mental health, medical and other needed support services can be provided at the required intensity and security measures are adequate. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects.

Transition planning for discharge to a lower level of service intensity is an essential part of the service plan. Discharge planning meetings attended by both inpatient and community services providers are mandatory for a safe transition to a community setting. Ideally, the step-down plan represents a modification of the comprehensive Level Five service plan, providing continuity of care and sustaining the gains made. It is essential for the Child and Family Team to remain active even when a child in a residential treatment center or hospital setting.

- 1. CLINICAL SERVICES.** Every child or adolescent requiring Level Six services can be presumed to be in a crisis state, and therefore, clinical services should reflect the highest level of service intensity and restrictiveness for the protection of the child or adolescent, the family, and the community. Clinical services must be comprehensive and relevant to the emergent and safety issues at hand. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Medication management plus intensive individual and family psychotherapy services are required, aimed at managing the crisis, decreasing the risk of harm, and restoring previous levels of functioning. Substance abuse services at Level Six may include medical detoxification. The individualized service plan must address management of aggressive and/or suicidal or self-endangering behavior.

Services at Level Six may be organized by a child and adolescent psychiatrist supervising the care provided by the multi-disciplinary service team, in partnership with the child or youth's caregivers. Active child psychiatric management is required at this level of service intensity and daily contact with the child or adolescent is necessary. The child and adolescent psychiatrist should consult regularly with the family and the child/youth and family team to ensure integration of Level Six services with the care provided at lower levels of service intensity in the community. Review of the child or adolescent's status by the service team should occur daily, with the goal of transition planning for return to lower levels of care, with attention to coordination with the Child and Family Team that will support the child/youth and family in the community setting. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care. Treatment for co-occurring medical conditions must be integrated into all treatment

plans.

2. **SUPPORT SERVICES.** All necessities of living and well-being must be provided for children and adolescents receiving services at Level Six regardless of whether the services are provided in a facility or in a community-based setting. The children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. The Child and Family Team must be very active to either coordinate a very intensive community-based Wraparound Plan or to ensure that all needed services or supports are in place when the child or adolescent leaves an inpatient setting. Families are likely to need support for financial, housing, child-care, vocational, legal and/or educational services. Service planning and care coordination transition to lower service intensity levels should begin while the child or adolescent receives Level Six services. Discharge planning should include integration of the child or adolescent into the home and community, and linkage with child welfare, education, juvenile justice, and recreational resources as needed. All support services should be described in the Individualized Service Plan.
3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. Emergency medical services must be available on-site or in close proximity and all staff should have training in emergency protocols.
4. **CARE ENVIRONMENT.** In most cases, Level Six care traditionally has been provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. These settings must be free of potentially harmful items, with adequate staffing to monitor the child or adolescent. Services and staff also should provide protection from potential abuse from others. Adequate temporary accommodations for family members must be available so that they can be available to participate in the child or adolescent's treatment.

Placement Criteria

Children and adolescents with scores of 28 or higher are appropriate for services at Level Six. Consideration for this level of service intensity should include the age, size, and manageability of the child or adolescent, and the family and community resources available.

COMPOSITE SCORE (Level 6)

28 or higher

LEVEL OF SERVICE INTENSITY COMPOSITE SCORE TABLE

<u>LEVEL</u>	<u>DESCRIPTION</u>	<u>SCORE</u>
\ gtq"	Dcule"Ugtxlegu"lqt"Rt gxgpvkp"cpf "O clpvGPCpeg"	9/; "
Qpg"	Tgeqxt { "O clpvGPCpeg"cpf "J gcmj "O cpci go gpv"	32/35"
"	"	"
Vy q"	Qwr cvkpv"Ugtxlegu"	36/38"
"	"	"
Vj tgg"	Kvvpukxg"Qwr cvkpv"Ugtxlegu"	39/3; "
"	"	"
Hqt"	Kvvpukxg"Kvvi tcvf "Ugtxlegu"Y kj qw"46/J qwt"Ru{ ej kvle"	42/44"
"	O qpksqtkpi "	"
Hxg"	P qp/Ugewtg."46/J qwt"Ru{ ej kvle"O qpksqtkpi "	45/49"
"	"	"
Ukz"	Ugewtg."46/J qwt"Ru{ ej kvle"O cpci go gpv"	4: - "

CASII
Service Intensity Level Determination Grid

Dimension	Recovery Maintenance Health Management Service Level 1	Outpatient Services Service Level 2	Intensive Outpatient Services Service Level 3	Intensive Integrated Services Without 24-Hour Psychiatric Monitoring Service Level 4	Non-Secure, 24-Hour Services With Psychiatric Monitoring Service Level 5	Secure 24-Hour Services With Psychiatric Management Service Level 6
I. Risk of Harm Score	2 or less	2 or less	3 or less	3 or less	3 ④	4 ⑤
II. Functional Status Score	2 or less	2 or less	3 or less	3 or less	3 ④*	4 ⑤*
III. Co-Occurrence of Conditions Score	2 or less	2 or less	3 or less	3 or less	3 ④*	4 ⑤
IVA. Recovery Environment - Stress Score	Sum of IVA + IVB is 4 or less	Sum of IVA + IVB is 5 or less	Sum of IVA + IVB is 5 or less	3 or 4	4 or more	4 or more
IVB. Recovery Environment - Support Score				3 or less	4 or more	4 or more
V. Resiliency and/or Response to Services Score	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIA. Involvement in Services - Child or Adolescent Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIB. Involvement in Services - Parent/Primary Caregiver Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Score	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

○ Indicates that independent criteria require admission to this service intensity level regardless of composite score. *Independent criteria may be waived if the sum of the Recovery Environment sub-scale (IVA and IVB) scores = 2.

**In the composite score, include only the higher of the two Involvement in Services sub-scale scores: either VIA or VIB.

SECTION IV

CASE STUDIES

In this section, you will have an opportunity to use the information that has been presented in this manual. Part VIII contains two short vignettes written by the developers of the CASII. This section will allow you to test your ability to use the CASII effectively and to compare your results with those obtained by the developers of the instrument. Begin by carefully reading each vignette. Next place your scores for each of the dimensions on the CASII Worksheet, referring back to the written descriptions of the dimensions (page 10) as often as necessary. Then, transfer your results to the scoring sheet and add the dimension scores together to find the composite score. Referring back to the Level of Service Intensity Composite Score Table (page 63) and the Level of Service Intensity Determination Grid (page 51), you can now use the composite score to determine the actual level of service intensity. Finally, compare your result to the Case Results for each vignette.

LAURA

Laura, a 7-year old girl, was seen after stabbing a classmate with a pencil and threatening to kill her teacher. She has killed a cat at home by strangling it. She has frequent tantrums in which she destroys furniture. She refuses to follow directions at home or school. She has frequent fights with her older brother and sister. She has frequent time outs at school for hitting peers. She has been treated for asthma since age 2 years. She frequently visits the Emergency Room because of breathing difficulties. She often refuses to use her inhaler. She lives in the country with her mother and two siblings. The nearest neighbor lives a half mile away. Her father is in prison for cultivating marijuana. Mother is unemployed. Social Services has an active case due to reports that Laura is frequently hungry. She attends the family resource center at school but her mother seldom participates. Laura has been evaluated by the Mental Health Center staff at school but mother has refused to attend assessment or treatment sessions. Mother has given permission for school to give Laura Ritalin but will not obtain it for her daughter. When she does take medicine, Laura still refuses to do her work but is less aggressive. She thinks seeing the therapist is stupid. Note: Family resource centers provide counseling, tutoring, parent education, parenting skills training and referrals to outside agencies, some of which provide services at the school.

CASII WORKSHEET

Rater Name _____ Date: _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of service intensity using either the Placement Grid or the Decision Tree.

<p>I. Risk of Harm</p> <ol style="list-style-type: none"> 1. Low Potential for Risk of Harm 2. Some Potential for Risk of Harm 3. Significant Potential for Risk of Harm 4. Serious Potential for Risk of Harm 5. Extreme Potential for Risk of Harm <p style="text-align: right;">Score _____</p>	<p>IV. B. Recovery Environment - Environmental Support</p> <ol style="list-style-type: none"> 1. Optimal Supportive Environment 2. Adequate Supportive Environment 3. Limited Support in Environment 4. Minimal Supportive Environment 5. No Supportive Environment <p style="text-align: right;">Score _____</p>
<p>II. Functional Status</p> <ol style="list-style-type: none"> 1. Minimal Functional Impairment 2. Mild Functional Impairment 3. Moderate Functional Impairment 4. Serious Functional Impairment 5. Severe Functional Impairment <p style="text-align: right;">Score _____</p>	<p>V. Resiliency and/or Response to Services</p> <ol style="list-style-type: none"> 1. Full Resiliency and/or Response to Services 2. Significant Resiliency and/or Response to Services 3. Moderate or Equivocal Resiliency and/or Response to Services 4. Poor Resiliency and/or Response to Services 5. Negligible Resiliency and/or Response to Services <p style="text-align: right;">Score _____</p>
<p>III. Co-Occurrence: Developmental, Medical, Substance Use, and Psychiatric</p> <ol style="list-style-type: none"> 1. No Occurrence 2. Minor Occurrence 3. Significant Occurrence 4. Major Occurrence 5. Severe Occurrence <p style="text-align: right;">Score _____</p>	<p>VI. A. Child/Adolescent: Involvement in Services</p> <ol style="list-style-type: none"> 1. Optimal 2. Adequate 3. Limited 4. Minimal 5. Absent <p style="text-align: right;">Score _____</p>
<p>IV. A. Recovery Environment - Environmental Stress</p> <ol style="list-style-type: none"> 1. Absent Stressful Environment 2. Mild Stressful Environment 3. Moderate Stressful Environment 4. Serious Stressful Environment 5. Severe Stressful Environment <p style="text-align: right;">Score _____</p>	<p>VI. B. Parent/Primary Caretaker: Involvement in Services</p> <ol style="list-style-type: none"> 1. Optimal 2. Adequate 3. Limited 4. Minimal 5. Absent <p style="text-align: right;">Score: _____</p>
<p>Composite Score</p>	<p>Level of Service Intensity Recommendation</p>

Scoring Sheet

Child and Adolescent Service Intensity Instrument (CASII)

Name/Identifier:

Date:

Scorer:

Date of last scoring:

Reason for rescoring: Initial Follow-up (*circle one*). Below please note specific reason for current rating.

<u>Score (1-5)</u>	<u>Dimension</u>	<u>Justification</u>
I.	*Risk of Harm	
II.	*Functional Status	
III.	*Co-Occurrence	
IV.	**Recovery Environment	
A.	Environmental Stress	
B.	Environmental Support	
V.	Resiliency and/or Response to Services	
VI.	Involvement in Services (<i>record the higher of the two scores</i>)	
A.	Child/Adolescent	
B.	Parent and/or Primary Care Taker	

_____ Sum of 7 scores = Composite CASII score

_____ CASII derived recommendation for level of service intensity (*Consult Grid*)

_____ Clinical recommendation for level of service intensity

Justification if different than CASII recommendation

** Independent criteria require automatic admission to a higher level of service intensity regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six.*

*** Independent criteria may be waived if sum of IVA and IVB scores equal 2.*

CASE RESULTS

NAME: Laura

AGE: 7

DIMENSION I: RISK OF HARM

SCORE = 4

Serious risk of harm: Current homicidal ideation with expressed intentions and past history of such behavior.

DIMENSION II: FUNCTIONAL STATUS

SCORE = 4

Serious impairment: Inability to perform close to expected standards in school behavior and serious deterioration of interpersonal interactions.

DIMENSION III: CO-OCCURRENCE OF CONDITIONS

SCORE = 3

Significant co-occurrence: Laura has asthma, a condition that requires significant medical monitoring.

DIMENSION IV: RECOVERY ENVIRONMENT

ENVIRONMENTAL STRESS

SCORE = 4

Highly stressful environment: Her father is in prison and her mother is unemployed.

ENVIRONMENTAL SUPPORT

SCORE = 4

Minimally supportive environment: Family shows limited ability to participate in services and service planning.

DIMENSION V: RESILIENCY AND/OR RESPONSE TO SERVICES

SCORE = 4

Poor resiliency and response to services: Laura takes her medication inconsistently and thinks that seeing a therapist is stupid.

DIMENSION VI: INVOLVEMENT IN SERVICES

SCORE = 4

Adversarial: Mother has refused to attend assessment or treatment sessions at the mental health center. (The parental score is chosen because it is higher.)

TOTAL SCORE = 27

RECOMMENDED LEVEL OF SERVICE INTENSITY = Level 5 (Non-secure, 24-hour Services with Psychiatric Monitoring) (Note: Because the child in this vignette lives in a rural area, Level 5 services may not be available, so that the next highest level of service intensity could be utilized.)

DISCUSSION: Laura has multiple problems in all dimensions of the CASII. She will need intensive services from a multi-disciplinary team. She might require placement in a therapeutic foster home or a residential treatment center, depending on how effective the Wraparound process can be in meeting her and her family's needs in her home. Laura's Individual Service Plan (ISP) must address the need for services at every level of service intensity. Clinical services must include physician/APRN services for her asthma and management of her Ritalin, and therapy services for her and her mother's psychiatric needs. Support services should include a care coordinator to coordinate activities of daily living, including food, transportation and necessary financial support. A family partner may be helpful in supporting Laura's mother's participation in the team planning process and in carrying out tasks identified by the team. Should Laura's violent behaviors not respond to an intensive Wraparound process, the service team must be prepared to provide crisis stabilization services that may include out of home placement. The required care environment may become a therapeutic foster home, an inpatient hospitalization, or a residential treatment center. If so, the ISP must be modified to provide a safe and comfortable facility close to the child's home that continues to include the original service team.

JAMES

James is a 16-year-old male high school senior who had the onset one year ago of delusions that he had been placed on earth by God to become a famous rock musician who, through his music, would save mankind from evil. This young man played no musical instrument prior to the onset of his delusions. At the onset 1 year ago, he also had auditory hallucinations of God talking to him. This young man has very involved upper middle class parents committed to full participation in the best services possible for their son. He has been in services for one year, currently in a day treatment program at his public school. His delusion is still present, but he is able to test it to a limited extent. He remains ambivalent and at times still distrustful of his clinicians. He continues to self-medicate with excessive alcohol use that impairs his judgment. He has very poor grades in school and can seem at times withdrawn from family and peers. His substance abuse compounds his psychiatric difficulties and causes his functioning to deteriorate.

CASII WORKSHEET

Rater Name _____ Date: _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of service intensity using either the Placement Grid or the Decision Tree.

<p>I. Risk of Harm</p> <ol style="list-style-type: none"> 1. Low Potential for Risk of Harm 2. Some Potential for Risk of Harm 3. Significant Potential for Risk of Harm 4. Serious Potential for Risk of Harm 5. Extreme Potential for Risk of Harm <p style="text-align: right;">Score _____</p>	<p>IV. B. Recovery Environment - Environmental Support</p> <ol style="list-style-type: none"> 1. Optimal Supportive Environment 2. Adequate Supportive Environment 3. Limited Support in Environment 4. Minimal Supportive Environment 5. No Supportive Environment <p style="text-align: right;">Score _____</p>
<p>II. Functional Status</p> <ol style="list-style-type: none"> 1. Minimal Functional Impairment 2. Mild Functional Impairment 3. Moderate Functional Impairment 4. Serious Functional Impairment 5. Severe Functional Impairment <p style="text-align: right;">Score _____</p>	<p>V. Resiliency and/or Response to Services</p> <ol style="list-style-type: none"> 1. Full Resiliency and/or Response to Services 2. Significant Resiliency and/or Response to Services 3. Moderate or Equivocal Resiliency and/or Response to Services 4. Poor Resiliency and/or Response to Services 5. Negligible Resiliency and/or Response to Services <p style="text-align: right;">Score _____</p>
<p>III. Co-Occurrence: Developmental, Medical, Substance Use, and Psychiatric</p> <ol style="list-style-type: none"> 1. No Occurrence 2. Minor Occurrence 3. Significant Occurrence 4. Major Occurrence 5. Severe Occurrence <p style="text-align: right;">Score _____</p>	<p>VI. A. Child/Adolescent: Involvement in Services</p> <ol style="list-style-type: none"> 1. Optimal 2. Adequate 3. Limited 4. Minimal 5. Absent <p style="text-align: right;">Score _____</p>
<p>IV. A. Recovery Environment - Environmental Stress</p> <ol style="list-style-type: none"> 1. Absent Stressful Environment 2. Mild Stressful Environment 3. Moderate Stressful Environment 4. Serious Stressful Environment 5. Severe Stressful Environment <p style="text-align: right;">Score _____</p>	<p>VI. B. Parent/Primary Caretaker: Involvement in Services</p> <ol style="list-style-type: none"> 1. Optimal 2. Adequate 3. Limited 4. Minimal 5. Absent <p style="text-align: right;">Score: _____</p>
<p>Composite Score</p>	<p>Level of Service Intensity Recommendation</p>

Scoring Sheet

Child and Adolescent Service Intensity Instrument (CASII)

Name/Identifier:

Date:

Scorer:

Date of last scoring:

Reason for rescoring: Initial Follow-up (*circle one*). Below please note specific reason for current rating.

<u>Score (1-5)</u>	<u>Dimension</u>	<u>Justification</u>
I.	*Risk of Harm	
II.	*Functional Status	
III.	*Co-Occurrence	
IV.	**Recovery Environment	
A.	Environmental Stress	
B.	Environmental Support	
V.	Resiliency and/or Response to Services	
VI.	Involvement in Services (<i>record the higher of the two scores</i>)	
A.	Child/Adolescent	
B.	Parent and/or Primary Care Taker	

_____ Sum of 7 scores = Composite CASII score

_____ CASII derived recommendation for level of service intensity (*Consult Grid*)

_____ Clinical recommendation for level of service intensity

Justification if different than CASII recommendation

** Independent criteria require automatic admission to a higher level of service intensity regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six.*

*** Independent criteria may be waived if sum of IVA and IVB scores equal 2.*

CASE RESULTS

NAME: James

AGE: 16

DIMENSION I: RISK OF HARM

SCORE = 3

Significant risk of harm: Continued psychotic delusions and excessive use of alcohol impairs James' judgment. If specific examples of dangerous behavior secondary to alcohol or drug use are obtained from the clinical interview, then this dimension should be scored a 4, which would result in Level 5 service, automatically due to CASII Independent Criteria.

DIMENSION II: FUNCTIONAL STATUS

SCORE = 4

Serious functional impairment: Poor academic performance, well below expected standards. Frequent withdrawal from family and peers.

DIMENSION III: CO-OCCURRENCE OF CONDITIONS

SCORE = 4

Major co-occurrence: James' substance abuse is significant enough to worsen his psychiatric condition and cause his level of functioning to deteriorate.

DIMENSION IV: RECOVERY ENVIRONMENT

ENVIRONMENTAL STRESS

SCORE = 1

Minimally stressful environment: His family is able to meet all his material needs. There are no enduring difficulties in his environment and his life circumstances are stable.

ENVIRONMENTAL SUPPORT

SCORE = 1

Highly supportive environment: James' parents are fully committed to full participation in high-quality services for their son.

DIMENSION V: RESILIENCY AND/OR RESPONSE TO SERVICES HISTORY

SCORE = 4

Poor resiliency and response to services: James continues to be symptomatic (continuing delusional beliefs). There have been no periods of sustained recovery, most likely due to his substance abuse.

DIMENSION VI: INVOLVEMENT IN SERVICES

SCORE = 4

Adversarial: James is still frequently distrustful of his clinicians after one year of services. He remains ambivalent about his participation in the therapy. (In contrast, his parent's engagement is rated as optimal, but the higher score is always used in this dimension.)

TOTAL SCORE= 21

RECOMMENDED LEVEL OF SERVICE INTENSITY: Level 4 (Intensive Integrated Services without 24-Hour Medical Monitoring)

DISCUSSION: James' level of service intensity is not higher due to the low level of environmental stress and high degree of environmental support. This is very likely due to his parent's optimal engagement in the therapeutic process and their total support of his recovery. Care coordination is essential to coordinate his psychiatric and substance abuse services with his significant education needs. Identification of James' interest in music as a strength would lead to offering him guitar lessons as part of his Individualized (Wraparound) Service Plan. Vocational services are also an essential part of this plan. James' active involvement in a job and in a hobby that he enjoys may result in less time for (and less interest in) continued substance abuse. Engagement in services may also improve. James may benefit from support that can be offered by a youth peer mentor who can assist with his engagement with his treatment team, as well in supporting his reintegration into the community.

The score of 4 on both Functional Status and Co-Occurrence (Dimensions II and III) would, under most circumstances, result in automatic placement in Level 5 services under CASII Independent Criteria. However, because the sum of the Recovery Environment (Dimension IV) subscales, Environmental Stress and Environmental Support is 2, then James may be maintained at Level 4 services. However, any deterioration in the high level of support he receives or any increase in environmental stress would result in Level 5 placement.

CASII POST TRAINING TEST QUESTIONS

Introduction

1. For what age range is CASII designed?
2. For what disorders can the CASII be used to determine the service needs of children and adolescents?
3. Name the six evaluation dimensions of the CASII.
4. Describe the concept of levels of service intensity.

Instructions

5. If you are not sure which score to assign to a CASII dimension, what score do you choose?
6. As a general rule, how often should the CASII be administered?
7. When specific services described in a CASII level of service intensity are not available in your community, what services should be assigned? Why?
8. How do you resolve the differences between the recommended level of service intensity obtained from CASII and that determined on the basis of clinical judgment?

Dimension I: Risk of Harm

9. What are the components of Dimension I: Risk of Harm?
10. How would you score "binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors" on Dimension I: Risk of Harm?
11. True or False: The presence of a developmental disability in the parent may increase the Risk of Harm to the child.
12. A child has a parent with schizophrenia, who has also recently developed a substance abuse problem? Which of the following answers are correct?
 - a. The substance abuse is not as important as the schizophrenia.
 - b. The substance abuse is more important than the schizophrenia.
 - c. The parent's illness has no effect on the Risk of Harm to the child.
 - d. The development of substance abuse in a parent who has schizophrenia has a negative impact on the recovery environment and so increases the Risk of Harm to the child.
13. True or False: The potential Risk of Harm increased for a child from South America who

has just moved to the United States with parents who are unable to speak English and who are unemployed.

14. An adolescent with impulse control disorder (e.g. Fetal Alcohol Syndrome) lives with an unemployed single father. Which of the following statements are true about Dimension I: Risk of Harm?
- a. The Fetal Alcohol Syndrome increases the Risk of Harm because the patient is unpredictable.
 - b. The age of the adolescent is the most important factor.
 - c. The father's unemployment increases the Risk of Harm only if he is emotionally upset by the loss of his job.
 - d. The adolescent is securely attached to the father and so the Risk of Harm is negligible.

Dimensions II: Functional Status

15. What are the components of Dimension II: Functional Status?
16. How would you score "sporadic episodes during which some aspects of self-care and hygiene are compromised" on Dimension II: Functional Status?
17. How would you score "nearly complete inability to maintain any appropriate school behavior given age and developmental level" on Dimension II: Functional Status?
18. A child/adolescent with chronic and severe problems in peer and adult relationships has recently developed a friendship with someone who positively guides and gently controls the child/adolescent:
- a. True or False: The impact on Functional Status is through an improvement of the Recovery Environment determined by a re-administration of the CASII.
 - b. True or False: The impact on Functional Status is through an improvement in Involvement in Services determined by a re-administration of the CASII.
19. True or False: The impact of a ten pound weight loss in a 6 year old child should be assessed on both Dimensions II: Functional Status and Dimension III: Co-Occurrence of Conditions.
20. A child/adolescent with a psychiatric problem deteriorates in services due to side effects from medication. The following answer(s) is/are true:
- a. The number of medications the patient is taking is the only important factor.
 - b. The only medication to worry about is an anticonvulsant.
 - c. The gender of the patient is the most important issue.
 - d. The presence of side effects will have a negative impact on Functional Status.

Dimension III: Co-Occurrence of Conditions

21. What are the four domains of Dimension III: Co-Occurrence of Conditions?
22. How would you score "medical conditions that are present requiring significant medical monitoring such as diabetes or asthma" on Dimension III: Co-Occurrence of Conditions?
23. How would you score a "developmental disorder which seriously compromises the presenting psychiatric disorder" on Dimension III: Co-Occurrence of Conditions?
24. True or False: The impact of the co-occurrence of a medical illness such as diabetes or epilepsy on a child or adolescent will decrease if the condition responds to medical services.
25. Of the following statement(s) which is/are true in an adolescent whose substance abuse has changed from use of cocaine and alcohol to alcohol alone?
 - a. The impact of alcohol alone is less than that of alcohol and cocaine.
 - b. The decrease in co-occurrence will improve the adolescent's functional status.
 - c. Other co-occurrence issues such as co-existing medical or psychiatric conditions are not relevant.
 - d. The alcohol abuse can still have a negative impact on Involvement in Services, Acceptance and Engagement.

Dimension IV: Recovery Environment

26. What are the components of Dimension IV: Recovery Environment?
27. How are CASII ratings on Dimension IV: Recovery Environment to be made on children or adolescents in residential treatment environments?
28. How would you score an environment that has "somewhat inadequate material resources or a threat of loss of resources due to parental unemployment or separation" on Dimension IV: Recovery Environment?
29. How would you score an environment in which a child or adolescent has witnessed physical or sexual abuse on Dimension IV: Recovery Environment?
30. How would you score an environment where "family and ordinary community resources are adequate to address the child's developmental and material needs" on Dimension IV: Recovery Environment?
31. How would you score an environment that fails to provide education, recreation, peer relationships on Dimension IV: Recovery Environment?
32. A child or adolescent has a step parent they do not like who leaves the home. Which of

the following is/are true:

- a. This has no effect on the Recovery Environment.
 - b. This affects the Environmental Stress only.
 - c. It affects the child more than the adolescent.
 - d. It affects both Environmental Stress and Environmental Support.
33. A single parent has become involved with a new partner who does not like or want children.
- a. True or False: The Environmental Support increases.
 - b. True or False: The Environmental Stress increases.

Dimension V: Resiliency and/or Response to Services

34. What are the components of Dimension V: Resiliency and/or Response to Services?
35. True or False: The service response of a child or adolescent is always related to the level of intensity of the service.
36. True or False: A child or adolescent's most recent experience in services takes precedence over past service experience in determining the CASII score.
37. How can you determine Resiliency in a young child who has not been involved in services?
38. True or False: Response to services is improved in a child or adolescent who did not connect with two previous female therapists but is now responding to a new male therapist.

Dimension VI: Involvement in Services

39. What are the two subscales of Dimension VI: Involvement in Services?
40. Cultural factors affect all of the dimensions of the CASII. Specifically, how do cultural factors affect Dimension VI: Involvement in Services?
41. What are the rules for use of the two sub-scale scores (parent/primary caretaker and child/adolescent) of Dimension VI: Involvement in Services?
42. What does the child or adolescent's Involvement in Services sub-scale on Dimension VI measure?
43. How would you score an adolescent who had an "actively hostile relationship with clinicians and other care providers" on Dimension VI: Involvement in Services?
44. What does the parent/primary caretaker sub-scale of Dimension VI measure?

45. How would you score a family with "no awareness of the problem" on Dimension VI: Involvement in Services?
46. Which of the following will occur in an adolescent who has a drug-induced psychosis during his course of services?
- a. There will be little effect on Involvement in Services.
 - b. There will be a negative effect on Involvement in Services.
 - c. The Risk of Harm will be decreased.
 - d. The involvement of the parent/primary caretaker is important.

LEVEL OF SERVICE INTENSITY CRITERIA

47. What are the seven levels of service intensity identified in the CASII?
48. True or False: In children and adolescents' services, the highest level of service intensity is always in patient hospitalization.
49. Describe the use of Wraparound principles in the various levels of service intensity of the CASII.
50. At which level(s) of service intensity does a child or adolescent's service needs "require the involvement of multiple components within the system of care"?

POST TRAINING ANSWERS

Introduction

1. In most cases, the CASII may be applied to children ages 6 through 18 years.
2. Though the CASII was developed to determine the service needs of children and adolescents with Serious Emotional Disturbance, the instrument applies equally well to children and adolescents with a broader range of presenting problems, including mental illness, substance use disorder, developmental disorder, and medical comorbidities.
3.
 - 1) Risk of Harm
 - 2) Functional Status
 - 3) Co-Occurrence of Conditions: Developmental, Medical, Substance Use, and Psychiatric
 - 4) Recovery Environment
 - a) Scale A = Environmental stress
 - b) Scale B = Environmental support
 - 5) Resiliency and/or Response to Services History
 - 6) Involvement in Services
 - a) Scale A = child/adolescent
 - b) Scale B = parent/primary caretaker
4. Level of service intensity is a programmatic concept recognizing the need for changes in service environment beyond just bricks and mortar considerations, based on a System of Care approach to service planning and service delivery. The levels of service intensity have been defined to reflect two interrelated but independent aspects of service: restrictiveness and intensity.

Instructions

5. Should there be ambiguity about which score to assign on a dimension, clinical judgment and experience should be applied to make the best determination of a score. When significant doubt remains, the higher score in the dimension should be assigned.
6. The CASII should be administered at the beginning of services, at points of significant change, at service plan reviews and at termination of service.
7. The combination of services closest to the recommended level of intensity and/or restrictiveness that is available in the community should be assigned, unless there is a clear and compelling rationale to do otherwise. This practice reflects the value of treating children and adolescents within their communities, instead of seeking service remotely, which increases barriers for family and community integration both during and after services.
8. If there is a difference between clinical judgment and the CASII level of service intensity,

clinical judgment supported by a clearly articulated rationale will take precedence.

Dimension I: Risk of Harm

9. This dimension of the assessment considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others.
10. Score of 3: Significant Risk of Harm
11. True
12. d: The development of substance abuse in a parent who has schizophrenia has a negative impact on the recovery environment and so increases the Risk of Harm to the child.
13. Yes
14. a: The Fetal Alcohol Syndrome increases the Risk of Harm because the patient is unpredictable.
c: The father's unemployment increases the Risk of Harm only if he is emotionally upset by the loss of his job.

Dimension II: Functional Status

15. This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, deterioration in eating and sleeping habits, and capacity for self-care.
16. Score of 2: Mild functional impairment.
17. Score of 5: Severe functional impairment.
18. a. True
b. True
19. True
20. d: The presence of side effects will have a negative impact on Functional Status.

Dimension III: Co-Occurrence of Conditions: Developmental, Medical, Substance Use, and Psychiatric

21. The four domains are:
1-developmental
2-medical
3-substance use
4-psychiatric

- 22. Score of 3: Significant co-occurrence
- 23. Score of 5: Severe co-occurrence
- 24. True
- 25. b: The decrease in co-occurrence will improve the adolescent's functional status
d: The alcohol abuse can still have a negative impact on Involvement in Services.

Dimension IV: Recovery Environment

- 26. This dimension has two components:
 - 1) Environmental stress: stressful circumstances may include interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities.
 - 2) Environmental support: supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members and then, factors such as the availability of adequate housing and material resources; stable, supportive, and ongoing relationships with friends, employers or teachers, clergy, professionals, and other community members.
- 27. For children living in residential or otherwise protected or enriched environments, ratings should be based on conditions that will be encountered on transition to a new environment or back to their pre-service environment.
- 28. Score of 2: Mild stressful environment
- 29. Score of 5: Severe stressful environment
- 30. Score of 1: Optimal supportive environment
- 31. Score of 5: No supportive environment
- 32. d: It affects both Environmental Stress and Environmental Support
- 33. a. False
b. True

Dimension V: Resiliency and/or Response to Services

- 34. This dimension recognizes that a child or adolescent's natural history of response to developmental challenges and stressors (resiliency) may indicate how that child or adolescent may respond to services. This dimension also assesses the family unit's ability to respond constructively to stressors and services.

35. False. Service response in some cases may not be related to the level of intensity, but rather to the unique characteristic of the service provider such as his/her level of cultural competency.
36. True
37. Responses to developmental challenges without professional involvement may be as indicative of resiliency as response to services.
38. True

Dimension VI: Involvement in Services

39. The Involvement in Services dimension measures both the child or adolescent's and the parent and/or primary caretaker's acceptance of and engagement in services.
40. A parent and/or primary caretaker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Thus, care should be taken to note barriers to proper assessment and services based on cultural differences between the child or adolescent and parent and/or primary caretaker and the clinician.
41. Only the highest of the two sub-scale scores is added into the composite score. In addition, if a child or adolescent is emancipated, the parent/primary caretaker sub-scale is not scored.
42. This sub-scale measures the ability of the child or adolescent, within developmental constraints, to: form a positive therapeutic relationship with people in components of the system providing services; define the presenting problems; accept his or her role in the development and perpetuation of the primary problem; accept his or her role in the service planning and service process; and to actively cooperate in services.
43. Score of 4: Adversarial
44. This sub-scale measures the ability of the parents or other care givers to: form a positive therapeutic relationship; engage with the clinician in defining the presenting problem; explore their role as it impacts on the primary problem; and take an active role in the service planning and process.
45. Score of 5: Inaccessible
46. b: There will be a negative effect on Involvement in Services
d: The involvement of the parent/primary caretaker is important.

LEVEL OF SERVICE INTENSITY CRITERIA

47. Level 0: Basic services for prevention and maintenance
 Level 1: Recovery maintenance and health management
 Level 2: Outpatient services
 Level 3: Intensive outpatient services
 Level 4: Intensive integrated services without 24-hour psychiatric monitoring
 Level 5: Non-secure, 24-hour services with psychiatric monitoring
 Level 6: Secure, 24-hour services with psychiatric management
48. False. The highest level of service intensity may not be inpatient hospitalization, but rather, intensive home-based services, such as those described in the Wraparound principles concept. Likewise, the most restrictive level of service is not inpatient service, but rather, may be services at different levels of intensity occurring within juvenile justice settings.
49. As the intensity of service increases, so does the need for individualization of the service plan in order to meet the child or adolescent's multiple needs in a community-based setting. The principles of Wraparound, including strength-based planning, use of natural and professional supports and use of parent-directed child/youth and family teams to develop and implement the service plan allow for high intensity services (CASII Levels of Care Four, Five and Six) to be provided in community settings.
50. Levels 4, 5, and 6.

SAMPLE QUESTIONS FOR THE DIMENSIONS OF THE CASII

Most professionals and organizations will utilize their own standardized evaluation or assessment instrument to gather clinical information to use with the CASII instrument. Hence, these sample questions do not replace a clinical interview. It is assumed that the sample questions will be incorporated into a comprehensive, clinically astute, developmentally appropriate interview conducted by a trained practitioner with expertise in interviewing children, adolescents and families.

These sample questions are provided to familiarize the user with the CASII criteria within each dimension of the instrument, and are meant to assist the practitioner in developing comprehensive information within each of the dimensions of the CASII.

DIMENSION I. RISK OF HARM

Child/Adolescent:

1. Have you ever had thoughts of hurting yourself?
2. Have you ever had thoughts of taking your life?
3. Have you had thoughts of killing yourself recently?
4. Do you have a plan for how you might kill yourself?
5. Have you ever harmed yourself in any way?
6. Has anyone in your family ever tried to take their life?
7. Have you ever lost a friend to suicide?
8. Have you ever lost a friend to violence?
9. Have you ever thought of hurting anyone else?
10. Have you ever thought of killing anyone else?
11. Have you ever harmed anyone else?
12. Have you ever hurt any animals?
13. Have you ever killed any animals?
14. Have you ever been involved in any sexual activity?
15. Have you ever been sexually aggressive toward anyone?
16. Have you ever had any thoughts about sexually threatening or injuring anyone?
17. Has anyone ever hit you? (Inquire about physical abuse)
18. Has anyone ever touched you in a way that made you feel uncomfortable? (Inquire about sexual abuse)
19. Have you ever been sexually threatened or injured by anyone?
20. Do fires excite you?
21. Do you play with matches?
22. Have you ever started any fires?
23. Is your home safe?
24. Is your school safe?
25. Is your neighborhood safe?
26. Have you ever tried drugs, alcohol or tobacco?
27. If so, has anything bad ever happened to you or to others while you were drunk or high?
28. While you were drunk or high, have you ever done anything that you regretted later?
29. Do you take care of yourself as well as other kids your age?

Parent/Primary Caretaker:

1. Has the child had any thoughts of hurting himself/herself?
2. Has the child had any thoughts of taking her/his life own life?
3. If so, has the child described to you how he/she might harm himself/herself?
4. Has the child ever harmed himself/herself in any way?
5. Has anyone in the child's family ever harmed themselves?
6. Is there a history of suicide in the family?
7. Has the child lost a friend to suicide?
8. Has the child lost a friend to violence?
9. Has the child ever talked of hurting anyone else or killing anyone else?
10. Has the child ever harmed anyone else?
11. Has the child ever hurt any animals?
12. Has the child ever been physically aggressive toward others?
13. Has the child been involved in any sexual activity?
14. Has the child been sexually aggressive toward anyone?
15. Has the child been fascinated with fire?
16. Does the child play with matches?
17. Has the child ever started any fires?
18. Does the child care for himself/herself in a way to maintain safety?
19. Does the child care for himself/herself as expected for his/her age?
20. Is the child's neighborhood safe?
21. Is the child's school safe?
22. Are you concerned that your child might be at risk for abuse or neglect?
23. As far as you know, has the child ever been abused or neglected?
24. Do you have concerns that your child might be using drugs, alcohol or tobacco?
25. If so, has your child put himself/herself or others in danger while using drugs or alcohol?
26. Do you think that the use of drugs has made your child's other problems more severe?

DIMENSION II. Functional Status

Child/Adolescent

1. How are your grades?
2. How do you get along with your friends at school?
3. How do you get along with your teachers?
4. Do you get into trouble at school because of your behavior?
5. How do you get along with your parents?
6. How do you get along with the other adults in your home?
7. How do you get along with your brothers and sisters?
8. Do you get into trouble at home because of your behavior?
9. Do you have any problems with your eating?
10. Do you have any problems with your sleeping?
11. Do you ever have bed-wetting or soil your underwear? (Inquire about bowel and bladder control)?
12. How do you handle stress in your life?

13. When you are having trouble do you let other people help you?

Parent/Primary Caretaker:

1. What are your child's grades in school?
2. Does your child have friends at school?
3. How does your child get along with teachers at school?
4. Does your child have any behavior problems at school?
5. How does your child get along with you at home?
6. How does your child get along with other adults?
7. How does he/she get along with his/her brother and sisters?
8. How does your child get along with his/her friends?
9. Does your child have any behavior problems at home?
10. Does your child have any problems with eating habits?
11. Does your child have any problems with sleeping?
12. Does your child have any problems with bowel or bladder control? (bedwetting or soiling)?
13. How does your child handle stress?
14. Does your child have difficulties accepting help from others?

DIMENSION III. Co-Occurrence of Conditions: Developmental, Medical, Substance Use, and Psychiatric

Child/Adolescent:

1. Do you have any physical, medical or mental problems?
2. Tell me about those problems? (Remember to inquire about substance abuse problems.)
3. What things have you tried to help with these problems?
4. Has anything helped to make these problems better?
5. Do you have problems reading, writing, or with math?

Parent/Primary Caretaker:

1. Does your child have any physical, medical or mental problems?
2. Tell me about those problems? (Remember to ask about substance abuse problems.)
3. What have you tried to help your child?
4. Has anything helped to make your child's problems better?
5. Does your child have serious learning problems?
6. Does your child have serious developmental delays?

DIMENSION IV. Recovery Environment

Environmental Stress

Child/Adolescent:

1. What is your neighborhood like? (Please tell me about your neighborhood.)
2. Have you had any recent big changes for the worse in your life?
3. Have you had any recent big changes for the better in your life?
4. Besides the changes you mentioned do you see any more changes (good or bad) coming in the near future?
5. Does your family have enough money to take care of basic needs (food, clothes, housing)?
6. Are you frightened for any reason in your school or home?
7. Are you meeting your parents/primary caretaker's expectations with your grades?
8. Are you meeting your parents/primary caretaker's expectations with your activities at home?
9. Are your friends sometimes hurtful to you?
10. Are you meeting the expectations of your teachers?
11. Are you meeting the expectations of your siblings in how you behave at home?
12. Are you meeting the expectations of other important people in your life? (coaches, friends, mentors and other family members)?

Parent/Primary Caretaker:

1. What do you see as the strengths in the child's environment?
2. What is the child's environment like at home and at school?
3. What needs does your child have that aren't being met?
4. Has your child had any recent changes or losses?
5. Does your child meet your expectations?
6. Do you think your child meets his/her sibling expectations?
7. Are you or any of the adults in the home having any emotional problems, financial problems or other significant problems?

Environmental Support

Child/Adolescent:

1. Is there anyone in your family that you can go to if you need help?
2. Is there anyone in your school that you can go to if you need help?
3. Is there anyone in your neighborhood that you can go to if you need help?
4. Is there anyone else that you can go to if you need help?
5. When you have a problem do your friends support you?
6. Where do you go if you need food?
7. Where do you go if you need clothes?
8. Where do you go if you need to feel safe?
9. Do you now feel safe at home?
10. Do you now feel safe at school?
11. Do you now feel safe in your neighborhood?

12. Do you have a safe place to play or get together with your friends?
13. Do you have a church or religion that supports you?

Parent/Primary Caretaker:

1. Are your family resources adequate to meet your child's developmental and material needs?
2. Does the community have resources to help you meet your child's developmental and material needs?
3. Do those who are helping you work with each other?
4. Is there at least one family member or primary caretaker always able and willing to provide for the child's developmental, material and service needs?
5. Do you know how to go about getting the community resources you need to adequately address your child's developmental and material needs?
6. What role does your church or religion play in your support system?

DIMENSION V. Resiliency and/or Response to Services

Child/Adolescent:

1. How do things go for you when you have to do difficult things?
2. How do things go for you when you have to do new things?
3. Have you had any really bad things happen to you, like a flood or a tornado?
4. How did things go for you after these bad things happened to you?
5. How do you think your family handles problems?
6. How have you responded to deaths in your family?
7. Do you think your family bounces back quickly or slowly when something goes wrong?
8. Have you ever received services for medical problems, behavioral problems, emotional problems or substance abuse?
9. Have you ever been hospitalized for medical problems, emotional problems, behavioral problems or substance abuse?
10. Did any of the services that you have received help you?

Parent/Primary Caretaker

1. How do you think your family handles problems?
2. How has the family responded to major life events such as deaths, natural disasters?
3. Do you think your family bounces back quickly or slowly when something goes wrong?
4. Has the child ever received services for medical problems, emotional problems, behavioral problems or substance abuse?
5. Has anyone in the family or has the primary caretaker ever received services for medical problems, emotional problems, behavioral problems or substance abuse.
6. How has the child responded to services for medical problems, emotional problems, behavioral problems or substance abuse?
7. Has the child ever been hospitalized for medical problems, emotional problems, behavioral problems or substance abuse?
8. Have any members of the family and/or the primary caretaker ever received services for medical

- problems, behavioral problems, emotional problems or substance abuse?
9. Have any members of the family and or the primary caretaker been hospitalized for medical problems, behavioral problems, emotional problems or substance abuse?
 10. How did the family member and/or the primary caretaker respond to services?

DIMENSION VI. Involvement in Services

Child or Adolescent Acceptance and Engagement

Child/Adolescent:

1. What do you think of your therapist/care provider?
2. Do you like your therapist/care provider?
3. Do you trust your therapist/care provider?
4. Can you talk to your therapist easily?
5. What is the problem that brought you to a therapist?
6. What are the problems that other people (for instance, your parents or teachers) think you have that bring you to a therapist?
7. What part do you play in your problems?
8. Do your problems have any effect on others?
9. Do you try to help your therapist solve your problems?
10. Do you think medication can be helpful with your problem?
11. If medicines have been prescribed for you, do you take your medication regularly?
12. If you do not take your medications regularly, why?(side effects or stigma)
13. How do you feel about receiving services?
14. Does your therapist understand your culture?
15. Does your therapist understand your beliefs?

Parent/Primary Caretaker:

1. What kind of relationship has your child formed with the therapists and/or care providers that are working with him/her?
2. Has your child been able to explain his/her problems to you?
3. Has your child been able to accept other people's explanation of his/her problems?
4. Has the child been able to accept responsibility for the consequences of problems?
5. Does your child actively cooperate in solving his/her problems?
6. Do you think your child trusts his/her therapist?
7. Do you think that medication can be helpful with your child's problem?
8. If medications have been prescribed for your child, does your child take those medications regularly?
9. If your child does not take his/her medications regularly, why not? (side effects, stigma)
10. How does the child's peers react to the child because of his/her treatment?
11. Do you have difficulty supporting your child's service plan because of transportation, costs, or other demands on you or your family?

Parent or Primary Caretaker Acceptance and Engagement

Child/Adolescent:

1. Do you think your parents like your therapists and/or care providers?
2. Do you think your parents understand your problems?

3. Do you think your parents contribute to your problems?
4. Do your parents understand your strengths and needs and how they affect your problem?
5. Do your parents understand how they can help with your services and recovery?

Parent/Primary Caretaker:

1. What kind of relationship do you have with your child's therapists and/or care providers?
2. Do you respect the therapist?
3. Does the therapist respect you?
4. Do you trust the therapist?
5. Can you talk to your child's therapist easily?
6. How do you understand your child's problem?
7. What are your child's strengths and needs as they relate to his/her problems?
8. How do you think that you have contributed to your child's problems?
9. How do you think you can contribute to your child's successful care and recovery?

APPENDIX A

Updated System of Care Concept and Philosophy (Stroul, et al, 2008)

DEFINITION

A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, which is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help the child or youth to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

APPENDIX B

RESOURCES

- AACAP. Best Principles for Integration of Child Psychiatry into the Pediatric Health Home. [http://www.aacap.org/App Themes/AACAP/docs/clinical practice center/systems of care/best principles for integration of child psychiatry into the pediatric health home 2012.pdf](http://www.aacap.org/App%20Themes/AACAP/docs/clinical%20practice%20center/systems%20of%20care/best%20principles%20for%20integration%20of%20child%20psychiatry%20into%20the%20pediatric%20health%20home%202012.pdf) Approved June 2012. Accessed May 25, 2014.
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APPENDIX C

CASII PSYCHOMETRICS AND EVIDENCE

In order to determine the scale's ability to perform, validity and reliability were tested in a national field study funded by the Center for Mental Health Services through the American Institute for Research. Four study sites were recruited:

1. An academically sponsored community based program in Philadelphia;
2. A network of day treatment providers in Portland, Oregon;
3. The public child mental health service agency for the state of Hawaii and;
4. The public mental health agency for the state of North Carolina focusing on community mental health centers in the central and western regions of the state.

The study was reviewed and approved by the East Tennessee University Institutional Review Board. Clinicians were trained and data was collected between September 1999 and June 2000.

Psychometric testing of the CASII in this national field trial has indicated that this instrument can be used reliably by a broad range of clinicians, even with relatively brief training (6 hours). The general trend is that subscale scores for the child psychiatrist were more consistent, but the composite score balances out the inconsistencies for the non-psychiatrists providing an extremely reliable summary score even for clinicians with less extensive training and experience. Another finding was that psychiatrists tended to rate slightly lower (less severe) than non-psychiatrists. This is ideal as it would be preferable to have less experienced clinicians be more cautious, particularly with regard to safety issues.

Validity testing indicates that there is moderate correlation between conventionally used scales (CGAS and CAFAS) and the CASII, although there seems to be higher correlation between the CASII and the CAFAS - particularly the composite scores. This study trained clinicians in the use of the CASII but not in the use of the CAFAS or the CGAS. Both of these scales were being used routinely at the test sites. Clinicians were not tested on their proficiency of the CAFAS or the CGAS. It is also encouraging to see that those CASII sub-scales that measure the child alone correlate more highly with the CAFAS and CGAS scores, while those sub-scales that measure environment or engagement have much lower correlation - as would be expected - further supporting the validity of the CASII.

It is curious that co-occurrence of conditions correlated poorly with the CGAS. Although it would be expected that CGAS might take co-occurrence of conditions into account, it appears that it does not. It is also curious that environmental stress is highly correlated with CGAS. Although environmental stress is related to the child's clinical state, this correlation might be expected to be lower than say resiliency and/or response to services.

Reliability

Method

Seven clinical vignettes were constructed, each oriented to a particular level of service intensity. These vignettes were given to 16 child and adolescent psychiatrists and 78 non-psychiatrists (mostly case managers). The 16 child and adolescent psychiatrists had assisted in the construction of the CASII and thus were very familiar with the instrument. Each of these psychiatrists rated the 7 vignettes for a total of 105 ratings (the psychiatrist who constructed the vignette did not rate that vignette).

The 78 non-psychiatrists were trained on the CASII in a 6 hour workshop. These non-psychiatrists were mostly Master-level social workers with an average of 5 years experience (see Table 4 below). At the end of their training, these clinicians used the CASII to rate at least 2 of the 7 vignettes chosen at random for a total of 157 ratings. Intraclass correlation coefficients (ICC 2,2) as described by Shrout and Fleiss (1979) were calculated for the child and adolescent psychiatrists and non-psychiatrists separately.

The study demonstrated that the CASII has a high degree of inter-rater reliability when used by a broad range of clinicians, and in fact greater inter-rater reliability in clinicians with lower levels of training.

Non-Psychiatrist Raters

Training	Number	Average years of experience post training
BA training	12	1.5 years
Master training	64	5.2 years
PhD training	2	18.5 years

Results

As seen in the Table below, intraclass correlation coefficients for the sub-scales for physicians ranged between 0.73 and 0.93 while the composite score was 0.89. For the non-physicians, the subscale scores ranged from 0.57 to 0.95 while the composite score coefficient was 0.93. For all of the vignettes, non-psychiatrist rated cases an average of 1.9 points higher than psychiatrists on the total CASII score amounting to less than a full level of service intensity difference on ratings.

Intraclass Correlation Coefficients Comparing Raters on CASII Scores (ICC2,2)

	Child Psychiatrist Ratings	Non-Psychiatrist Ratings
Risk of Harm	.87	.95
Functional Status	.77	.71
Co-Occurrence of Conditions	.86	.81
Environmental Stress	.78	.57
Environmental Support	.93	.89

Resiliency and/or Response	.82	.85
Parent Involvement	.81	.79
Child Involvement	.73	.58
Composite Score	.89	.93

Validity

Methods

After training on the CASII, the non-psychiatrists (as described above) completed routine clinical evaluations and then rated these patients with the CASII and either the Child Global Assessment Scale (CGAS) as described by Shaffer et al. (1983) or the Child and Adolescent Functional Assessment Scale (CAFAS) as described by Hodges and Wong (1996). CAFAS scores were computed using the 8 CAFAS sub-scales. Patients, ages 6 to 18 years old, came from inpatient, outpatient, intensive community and residential settings. Modalities for outpatient treatment included individual, family, group psychotherapies, case management, and wraparound services. Pearson correlation coefficients compared the CASII ratings with the CGAS and CAFAS scores.

Results:

CGAS scores in this population of patients (n=182) varied from 23 to 81 with a mean of 40. CASII composite scores varied from 8 to 34 with a mean of 20.

Correlation of the CGAS with the sub-scale scores of the CASII varied 0.41 to 0 (See table below). Those sub-scale correlations related to the child's clinical presentation that would be expected to correlate with CGAS (functional status, risk of harm and resiliency and/or response to services) were 0.41 to 0.26 while those sub-scales having to do with environment and not related to the child directly (environmental support, parent involvement) were close to 0. The CASII Co-Occurrence of Conditions subscale was also close to 0.

It also demonstrated good external validity when compared with the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1998), and the Child Global Assessment Scale (CGAS) (Schaffer, 1983), particularly on dimensions that relate to functionality.

Correlation of CASII Scores With CGAS Scores (n=182)

	Correlation with CGAS
Risk of Harm	-.37
Functional Status	-.41
Co-Occurrence of Conditions	-.05
Environmental Stress	-.28
Environmental Support	-.05
Resiliency and/or Response	-.26

Parent Involvement	-.02
Child Involvement	-.24
Composite Score	-.33

All patients who had CGAS ratings also had CAFAS ratings. In addition, there were 432 patients who had only CAFAS ratings (total n =614 for CAFAS/CASII rating combinations). Mean CASII composite score on these 614 patients was 20 with a range of 8-34 while CAFAS composite score mean was 96 with a range of 0 to 200.

The table below shows the Pearson Correlation Coefficients between the CASII scores and the CAFAS composite score. As with the CASII/CGAS correlations, those CASII scales that reflect attributes about the child were moderately correlated with the CAFAS composite score: Risk of Harm, Functional Status and Resiliency and/or Response to Services. With the CAFAS scores, the Co-Occurrence of Conditions scale was more highly correlated than with the CGAS. Also, just as with the CGAS comparison, the CASII sub-scales having to do with environment and not related to the child directly (environmental support, parent involvement) was lower (.11 - .22). For comparison, for those patients who had both CAFAS and CGAS scores (n=182), this correlation was computed to be 0.50.

Correlation of CASII Subscale and Composite Scores With CAFAS Composite Score (n=614)

	Pearson Correlations with CAFAS composite score
Risk of Harm	.51
Functional Status	.52
Co-Occurrence of Conditions	.41
Environmental Stress	.35
Environmental Support	.22
Resiliency and/or Response	.50
Parent Involvement	.11
Child Involvement	.31
Composite CASII Score	.62
CGAS (n=182)	.50

Subsequent Studies

Subsequent studies have further established the CASII as a reliable and valid instrument in child welfare populations and juvenile justice populations as well as other child mental health settings. The CASII was evaluated in child welfare and juvenile justice populations in the context of the annual survey of children

in state custody by the state of Tennessee's Children's Placement Outcome Review Team (C-PORT) program (Pumariega, et al, 2006; Pumariega, et al, In Press). The studies demonstrated strong external validity correlations between the CASII Total Score and Recommended Level of Care not only to the CAFAS (Hodges and Wong, 1996) Total Score but also the Child Behavior Checklist, Youth Self Report, and Teacher Report Total and T scores (Achenbach, 1991). In both the child welfare and juvenile justice populations the CASII demonstrated a stronger correlation to the Child and Family Indicators outcomes measure of C-PORT than the actual level of care the youth was placed in. It also demonstrated the potential to step down a number of youth from unnecessarily high levels of care they were placed in, while demonstrating that some youth needed more intensive community-based services than they were receiving.

The Hawaii Child and Adolescent Mental Health Division has been using the CASII since 2001, being the first state that received system-wide training for their child welfare population. Daleiden (2004) reported on the results of the first two years' use of the CASII, including longitudinal rating of 3,305 children and youth over 10 fiscal quarters (July 2000 to June 2003). He found that the CASII had a strong concurrent validity versus the CAFAS as well as prospective validity demonstrated by continued correlations between CASII and CAFAS scores out to ten quarters, but also was significantly predictive validity for services restrictiveness and services cost. Daleiden et al (2006) also used the CASII as an outcomes evaluation instrument to measure population outcomes for the Hawaii statewide system of care and found that it demonstrated overall acceleration of improvement in the population as did the CAFAS over a four year period. Tolman et al (2008) also demonstrated that CASII total and level of care scores correlated to therapist assessment of improvement from Multisystemic Therapy in Hawaii's system of care, and that youth who improved had a mean reduction of 1 level of care (from 3.5 to 2.5).

The state of Minnesota also conducted its own pilot evaluation of the CASII in its child and adolescent mental health system (Children's Mental Health Division, Minnesota Department of Human Services, 2008). In its evaluation they rated 4239 children and youth for initial evaluation, 1679 at 6 months' evaluation, and 435 at 12 month follow-up. They found that CASII Scores ranged across all seven levels of care and decreased significantly from initial administration to 6-month follow-up and from 6-month follow-up to 12-month follow-up, suggesting that it discriminates between services needs and assesses changes in service needs and functioning over time. On average, children/adolescents that were identified by the CASII as having higher services need were recommended more hours of services and more hours of services by providers. CASII test-retest validity was similar to previous studies and comparable instruments. The CASII also was significantly correlated to all versions of the Strengths and Difficulties Questionnaire (Goodman, 1997), including the Parent SDQ, Teacher SDQ, and Self SDQ. CASII scores related significantly to all types of providers' service recommendations.

In summary, multiple studies in multiple service settings with diverse populations over the past 10 years have confirmed that the CASII is a reliable and valid instrument that is easy to use.

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APPENDIX D
CASII ANCHOR POINT QUICK REFERENCE SHEET
Dimension I. Risk of Harm

1. Low Risk of Harm	2. Some Risk of Harm	3. Significant Risk of Harm	4. Serious Risk of Harm (Requires Care at Level 5)	5. Extreme Risk of Harm (Requires Care at Level 6)
<p>A. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation</p> <p>B. No indication or report of physically or sexually aggressive impulses</p> <p>C. Developmentally appropriate ability to maintain physical safety and/or use environment for safety</p> <p>D. Low risk for victimization, abuse, or neglect</p> <p>E. Other</p>	<p>A. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention, and no significant distress</p> <p>B. Mild suicidal ideation with no intent or conscious plan and with no past history</p> <p>C. Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others</p> <p>D. Substance use without significant endangerment of self or others</p> <p>E. Infrequent, brief lapses in the ability to care for self and/or use environment for safety</p> <p>F. Some risk for victimization, abuse, or neglect</p> <p>G. Other</p>	<p>A. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child and family to contract for safety and carry out a safety plan. Child expresses some aversion to carrying out such behavior.</p> <p>B. No active suicidal/homicidal ideation, but extreme distress and/or history of suicidal/homicidal behavior</p> <p>C. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (ie status offenses, impulsive acts while intoxicated, self-mutilation, running away with voluntary return, fire-setting, violence toward animals, affiliation with dangerous peer group)</p> <p>D. Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors</p> <p>E. Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways</p> <p>F. Serious or extreme risk for victimization, abuse, or neglect</p> <p>G. Other</p>	<p>A. Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child has expressed ambivalence about carrying out the safety plan and/or family's ability to carry out the safety plan is compromised.</p> <p>B. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction, repetitive fire-setting or violence toward animals)</p> <p>C. Indication of consistent deficits in ability to care for self and/or use environment for safety</p> <p>D. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child or family to restrict use</p> <p>E. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety</p> <p>F. Other</p>	<p>A. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior: 1) without expressed ambivalence or significant barriers to not doing so, or 2) with a history of serious past attempts that are not of a chronic, impulsive or consistent nature, or in presence of command hallucinations or delusions that threaten to override usual impulse control</p> <p>B. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (eg fire setting with intent of serious property destruction or harm to others or self, planned and/or group violence) with history, plan, or intent, and no insight and judgment (forceful and violent repetitive sexual acts against others.</p> <p>C. Relentlessly engaging in acutely self-endangering behaviors</p> <p>D. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.</p> <p>E. Other</p>

APPENDIX D
CASII ANCHOR POINT QUICK REFERENCE SHEET
Dimension II. Functional Status

1. Minimal Functional Impairment	2. Mild Functional Impairment	3. Moderate Functional Impairment	4. Serious Functional Impairment (Requires Care at Level 5)	5. Severe Functional Impairment (Requires Care at Level 6)
<p>A. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/hygiene/ control of bodily functions.</p> <p>B. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative sleep, eating, energy, and self-care.</p> <p>C. Other</p>	<p>A. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationship with peers, adults, and/or family (eg defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems) or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention.</p> <p>B. Sporadic episodes during which some aspects of sleep, eating, energy, and self-care are compromised.</p> <p>C. Demonstrates significant improvement in function following a period of deterioration</p> <p>D. Other</p>	<p>A. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.</p> <p>B. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.</p> <p>C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.</p> <p>D. School behavior has deteriorated to the point that in-school suspension has occurred and the child or youth is at risk for placement in an alternative school or expulsion due to their disruptive behavior.</p> <p>E. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in constructive activities, and ability to maintain responsibilities.</p> <p>F. Recent gains and/or stabilization in functioning have been achieved while participating in services in a structured, protected, and or/ enriched setting.</p> <p>G. Other</p>	<p>A. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.</p> <p>B. Significant withdrawal and avoidance of almost all social interaction.</p> <p>C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.</p> <p>D. Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning.</p> <p>E. Inability to perform adequately even in a specialized school setting due to disrupted or aggressive behaviors. School attendance may be sporadic. The child has multiple academic failures.</p> <p>F. Other</p>	<p>A. Extreme deterioration in interactions with peers, adults and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.</p> <p>B. Complete withdrawal from all social interactions.</p> <p>C. Complete neglect of and inability to attend to self-care/hygiene/ control of biological functions with associated impairment in physical status.</p> <p>D. Extreme disruption in physical functions causing serious compromise of health and well-being.</p> <p>E. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.</p> <p>F. Other</p>

APPENDIX D

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension III. Co-Occurrence of Conditions: Medical, Substance Use, Developmental, and Psychiatric

1. No Co-Occurrence	2. Minor Co-Occurrence	3. Significant Co-Occurrence	4. Major Co-Occurrence (Requires Care at Level 5)	5. Severe Co-Occurrence (Requires Care at Level 6)
<p>A. No medical, substance abuse, developmental disability, or psychiatric disturbances apart from presenting problem.</p> <p>B. Past medical, substance use, developmental, or psychiatric conditions stable and pose no threat to child's or adolescent's current functioning or presenting problem.</p> <p>C. Other</p>	<p>A. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and or compensation.</p> <p>B. Self-limited medical problems are present that are not immediately threatening or debilitating and have no impact on the presenting problem and are not affected by it.</p> <p>C. Occasional, self-limited episodes of substance use are present that show no escalation, no indication of adverse effect on function or presenting problem.</p> <p>D. Transient, occasional, stress-related psychiatric symptoms are present that have no impact on presenting problem.</p> <p>E. Other</p>	<p>A. Developmental disability is present that may/does adversely affect the presenting problem, or require significant alteration of services for the presenting problem or co-occurring condition.</p> <p>B. Medical conditions are present requiring significant medical monitoring</p> <p>C. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem.</p> <p>D. Substance abuse is present, with significant adverse effect on functioning and the presenting problem.</p> <p>E. Recent substance use that has a significant impact on presenting problem and that has been arrested stopped due to use of a highly structured/protected setting or through external means.</p> <p>F. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.</p> <p>G. Other</p>	<p>A. Medical conditions present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring.</p> <p>B. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.</p> <p>C. Uncontrolled substance use that poses a serious threat to health if unabated and impedes recovery from presenting problem.</p> <p>D. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder.</p> <p>E. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.</p> <p>F. Other</p>	<p>A. Significant medical condition poorly controlled and/or potentially life threatening in absence of close medical management</p> <p>B. Medical condition acutely or chronically worsens or is worsened by the presenting problem.</p> <p>C. Substance dependence present, with inability to control use, intense withdrawal symptoms, & extreme negative impact on the presenting disorder.</p> <p>D. Developmental disorder that seriously complicates, or is seriously compromised by, the presenting disorder.</p> <p>E. Acute or severe psychiatric symptoms that seriously impair functioning, and/or prevent voluntary participation in treatment for presenting problem, or prevent recovery.</p> <p>F. Other</p>

APPENDIX D
CASII ANCHOR POINT QUICK REFERENCE SHEET
Dimension IV.A. Environmental Stress

1. Absent Environmental Stress	2. Mild Environmental Stress	3. Moderate Environmental Stress	4. Serious Environmental Stress	5. Severe Environmental Stress
<p>A. Absence of significant or enduring difficulties in environment and life circumstances are stable.</p> <p>B. Absence of recent transitions or losses of consequence</p> <p>C. Material needs met without significant cause for concern that they may diminish in the near future with no threats to safety or health.</p> <p>D. Living environment is conducive to normative growth, development, and recovery.</p> <p>E. Role expectations normative and congruent with child's age, capacities and/or developmental level.</p> <p>F. Other</p>	<p>A. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher.</p> <p>B. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, illness or death of distant extended family member that has a mild effect on child and family.</p> <p>C. Transient but significant illness or injury (pneumonia, broken bone).</p> <p>D. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, etc.</p> <p>E. Expectations for performance at home or school create discomfort.</p> <p>F. Potential for exposure to substance use exists.</p> <p>G. Other</p>	<p>A. Disruption of family/social milieu</p> <p>B. Interpersonal or material loss that has significant impact child and family.</p> <p>C. Serious prolonged illness or injury, unremitting pain, other disabling condition.</p> <p>D. Danger or threat in neighborhood or community, or sustained harassment by peers or others.</p> <p>E. Exposure to substance abuse and its effects.</p> <p>F. Role expectations that exceed child's or adolescent's capacity, given his/her age, status and developmental level.</p> <p>G. Other</p>	<p>A. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment.</p> <p>B. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence or immersion in alien and hostile culture.</p> <p>C. Inability to meet needs for physical and/or material well-being.</p> <p>D. Exposure to endangering criminal activities in family/community.</p> <p>E. Difficulty avoiding substance use and its effects.</p> <p>F. Other</p>	<p>A. Traumatic or enduring and highly disturbing circumstances, such as:</p> <ol style="list-style-type: none"> 1) Violence, sexual abuse or illegal activity in the home or community 2) The child or adolescent is witness to or a victim of natural disaster 3) The sudden or unexpected death of a loved one 4) Unexpected or unwanted pregnancy <p>B. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal status.</p> <p>C. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.</p> <p>D. Severe pain, injury or disability or imminent threat of death due to severe illness or injury.</p> <p>E. Other</p>

APPENDIX D
CASII ANCHOR POINT QUICK REFERENCE SHEET
Dimension IV.B. Environmental Support

1. Optimal Environmental Support	2. Adequate Environmental Support	3. Limited Environmental Support	4. Minimal Environmental Support	5. No Environmental Support
<p>A. Family and ordinary community resources are adequate to address child's developmental and material needs.</p> <p>B. Continuity of active, engaged care takers, with a warm, caring relationship with at least one care taker.</p> <p>C. Other</p>	<p>A. Continuity of family members/care takers is only occasionally disrupted, and/or relationships with family members/care takers are only occasionally inconsistent.</p> <p>B. Family/care takers willing and able to participate in treatment if requested and have capacity to effect needed changes.</p> <p>C. Special needs addressed through successful involvement in systems of care</p> <p>D. Community resources are sufficient to address child's developmental and material needs.</p> <p>E. Other</p>	<p>A. Family has limited ability to respond appropriately to child or adolescent's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.</p> <p>B. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.</p> <p>C. Family or primary care takers demonstrate only partial ability to make necessary changes during treatment.</p> <p>D. Other</p>	<p>A. Family or primary care taker is seriously limited in ability to provide for the child or adolescent's developmental, material, and emotional needs.</p> <p>B. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.</p> <p>C. Family and other care takers display limited ability to participate in treatment and/or service plan</p> <p>D. Other</p>	<p>A. Family and/or other care takers are completely unable to meet the child or adolescent's developmental, material, and/or emotional needs.</p> <p>B. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations and mentoring from unrelated adults.</p> <p>C. Lack of liaison and cooperation between child/youth-serving agencies.</p> <p>D. Inability of family or other primary care takers to make changes or participate in services</p> <p>E. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent and/or threatening others.</p> <p>F. Other</p>

APPENDIX D

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension V. Resilience and/or Response to Services

1. Full Resiliency	2. Significant Resiliency	3. Moderate/Equivocal Resiliency	4. Poor Resiliency	5. Negligible Resiliency
<p>A. Child/youth has demonstrated significant and consistent capacity to maintain development in the face of normal challenges.</p> <p>B. Prior experience indicates that efforts in most types of services have been helpful in controlling the presenting problem in a relatively short period of time.</p> <p>C. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent services.</p> <p>D. Able to transition successfully and accept changes in routine without support; optimal flexibility</p> <p>E. Other</p>	<p>A. Child/youth have demonstrated average ability to deal with stressors and maintain developmental progress.</p> <p>B. Previous experience with services has been successful in controlling symptoms but more lengthy intervention is required.</p> <p>C. Significant ability to manage recovery demonstrated for extended periods, but has required structured setting or ongoing care and/or peer support.</p> <p>D. Recovery has been managed for short periods of time with limited support or structure.</p> <p>E. Able to transition successfully and accept changes in routine with minimal support</p> <p>F. Other</p>	<p>A. Child/youth has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.</p> <p>B. Previous experiences with services at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.</p> <p>C. Recovery has been maintained for moderate periods, but only with strong professional/peer support or in structured settings.</p> <p>D. Developmental pressures and life changes have created temporary stress.</p> <p>E. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.</p> <p>F. Other</p>	<p>A. Child/youth has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.</p> <p>B. Previous services have not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated interventions.</p> <p>C. Attempts to maintain whatever gains that can be attained with intensive services have limited success, even for limited time periods or in structured settings.</p> <p>D. Developmental pressures and life changes have created episodes of turmoil or sustained distress.</p> <p>E. Transitions with changes in routine are difficult even with a high degree of support.</p> <p>F. Other</p>	<p>A. Child/youth has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.</p> <p>B. Past response to services has been quite minimal, even when treated at high levels of service intensity for extended periods of time.</p> <p>C. Symptoms are persistent and functional ability shows no significant improvement despite receiving services.</p> <p>D. Developmental pressures and life changes have created sustained turmoil and/or developmental regression.</p> <p>E. Unable to transition or accept changes in routine successfully despite intensive support.</p> <p>F. Other</p>

APPENDIX D

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension VI.A. Child or Adolescent Involvement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
<p>A. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.</p> <p>B. Able to define problem(s) as developmentally appropriate and accepts others' definition of the problem(s), and consequences.</p> <p>C. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.</p> <p>D. Cooperates and actively participates in services.</p> <p>E. Other</p>	<p>A. Able to develop a trusting, positive relationship with clinicians and other care providers.</p> <p>B. Unable to define the problem as developmentally appropriate, but accepts others definition of the problem and its consequences.</p> <p>C. Accepts limited age-appropriate responsibility for behavior.</p> <p>D. Passively cooperates in services.</p> <p>E. Other</p>	<p>A. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.</p> <p>B. Acknowledges existence of problem, but has trouble accepting limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.</p> <p>C. Minimizes or rationalizes problem behaviors and consequences.</p> <p>D. Unable to accept others definition of the problem and its consequences.</p> <p>E. Frequently misses or is late for appointments and/or does not follow the service plan.</p> <p>F. Other</p>	<p>A. A difficult and unproductive relationship with clinician and other care providers.</p> <p>B. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.</p> <p>C. Frequently disrupts assessment and services.</p> <p>D. Other</p>	<p>A. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.</p> <p>B. Unaware of problem or its consequences.</p> <p>C. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.</p> <p>D. Other</p>

APPENDIX D

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension VI.B. Parent/Primary Caregiver Involvement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
<p>A. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers.</p> <p>B. Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting problem.</p> <p>C. Sensitive and aware of their child or adolescent's problems and how they can contribute to their child's recovery.</p> <p>D. Active and enthusiastic participation in services assessment and services.</p> <p>E. Other</p>	<p>A. Develops positive therapeutic relationship with clinicians and other primary care takers.</p> <p>B. Explores the problem and accept others definition of the problem.</p> <p>C. Works collaboratively with clinicians and other care takers in development of service plan.</p> <p>D. Cooperates with service plan, with behavior change and good follow-through on interventions.</p> <p>E. Other</p>	<p>A. Inconsistent and/or avoidant relationship with clinicians and other care providers.</p> <p>B. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.</p> <p>C. Unable to collaborate in development of service plan.</p> <p>D. Unable to participate consistently in service plan, with inconsistent follow-through.</p> <p>E. Other</p>	<p>A. A difficult and unproductive relationship with clinician and other care providers.</p> <p>B. Unable to reach shared definition of the development, perpetuation, or consequences of problem.</p> <p>C. Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members.</p> <p>D. Engages in behaviors that are inconsistent with the service plan.</p> <p>E. Other</p>	<p>A. No awareness of problem.</p> <p>B. Not physically available.</p> <p>C. Refuses to accept child or adolescents, or other family members' need to change.</p> <p>D. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.</p> <p>E. Other</p>



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